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**H E Dr. Hong Sun Huot,
Senior Minister and Minister of Health
August 2002**

**KINGDOM OF CAMBODIA
MINISTRY OF HEALTH
HEALTH SECTOR STRATEGIC PLAN 2003-2007**

FOREWORD

I am very pleased to present this Strategic Plan for the further development of our country's health sector. Improving the health of the nation is at the heart of the policies of our Government. Although considerable progress has been made, as with the eradication of poliomyelitis, containment of HIV/AIDS and decrease in malaria, still too many women die in childbirth and our children go hungry and die from easily preventable diseases. Much more remains to be done in the years ahead.

This document provides the framework that will guide our efforts throughout the next five years. It reflects the values behind all that we do. In particular, we are determined that services should be equally available to all people, without discrimination by gender, age, ability to pay or place of residence. They must also especially focus on the needs of mothers and children as well as those of poor people. For them all, ill health can be a personal tragedy apart from being an economic burden that reinforces their impoverished circumstances.

To meet these ideals this plan includes strategies that will strengthen health services and improve outcomes. As a priority, we will target infant and maternal mortality rates with an aim to achieve significant improvements. The needs of deprived people in rural areas will receive special attention. We encourage the involvement of local communities in health affairs and intend to empower all people to take decisions based on informed choices. These proposals, together with many others in the plan, are all designed to improve the health of Cambodians and fulfill the Government's commitment, in 2002, to the ASEAN Nations ambitious Declaration on Healthy Lifestyles.

To bring about all the enhancements in clinical care and public health services we must also change and develop our support services. New ways of working must be brought in and greater emphasis be given to quality in all that we do. More efficient practices will be essential and systems and procedures must be revised. Seeking constant improvement must become our normal way of working. For all this we depend on the continued dedication of all our staff.

To make our ambitions possible, it will be essential to secure realistic funding. We are fortunate that this plan will be underpinned by support from many international partners, who are all committed to the same goals and outcomes. This strategic plan is the first step in moving towards sector wide management that weaves together all our efforts to improve health. This assistance, linked to our own Government's funding commitment will bring fruit to this plan. To all our donor partners and other external agencies, we are extremely grateful.

This Strategic Plan embodies our ambitions for a better and healthier future for all Cambodian people. I commend it most strongly.



H.E. Dr. Hong Sun Huot
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EXECUTIVE SUMMARY

The Mission of the Ministry of Health, Royal Government of Cambodia is commitment to ensure sector wide equitable, quality health care for all the people of Cambodia through targeting resources, especially to the poor and to areas in greatest need.

To achieve this mission, the ministry has developed a policy statement outlining future directions for the next 5 years, which have guided this strategic plan development.

In summary, the policy asserts that all people in Cambodia, of whatever gender, age, place of residence or ability to pay, should have equal access to good-quality, basic and essential specialised health services, staffed by competent health professionals, and at a cost people can afford; that they should have information that empowers them to make informed choices about matters affecting the health and well-being of themselves and their families.

Infant and child mortality rates have actually risen over recent years and the maternal mortality ratio remains unacceptably high. Around half of all children are malnourished. The burden of communicable disease, especially malaria, tuberculosis and HIV is heavy. And, at the same time, chronic conditions related to non-communicable diseases, and to injuries, are emerging as major public health issues.

Critical success factors on which to better plan and build the future have been identified. They include strong political commitment, visible and effective leadership and stewardship, ownership, timely provision of adequate funds, good planning, management, monitoring and evaluation systems at all levels, availability of competent staff and useful medicines, community participation in health activities and forming technical and funding partnerships within government and local non-governmental stakeholders as well as with external agencies.

To make significant progress towards the achievement of its mission and policy, Ministry of Health has adopted 20 strategies, of which 8 form the essential core, in 6 priority areas of work. These strategies are intended to be the focus for action by the Ministry and all health sector partners over the next 5 years.

The core 8 strategies are:

Health service delivery

1. Further improve coverage and access to health services especially for the poor and other vulnerable groups through planning the location of health facilities.
2. Strengthen the delivery of quality basic health services through health centers based upon minimum package of activities.
3. Strengthen the delivery of quality care, especially for obstetric and paediatric care, in all hospitals through measures such as the complementary package of activities.

Behavioural change

4. Change for the better the attitudes of health providers sector wide to become more responsive to consumer needs especially of the poor through sensitisation and building interpersonal skills.

Quality improvement

5. Introduce and develop a culture of quality in public health, service delivery and their management through the use of Ministry of Health quality standards.

Human resource development

6. Increase the number of midwives through basic training and strengthen the capacity and skills of midwives already trained through continuing education.

Health financing

7. Ensure regular and adequate flow of funds to the health sector especially for service delivery through advocacy to increase resources and strengthening financial management.

Institutional development

8. Organizational and management reform of structures, systems and procedures in the Ministry of Health to respond effectively to change.

Overall outcomes to be achieved by 2007 include reduced infant mortality rate, child mortality rate, maternal mortality ratio, total fertility rate, and household health expenditure especially among the poor, and a more effective and efficient health system.

Implementing the strategic plan is recognised as a critical next step that will involve all stakeholders – the government, all levels of the Ministry of Health, all partners, consumers and even private sector providers. Sector wide management, an approach recently adopted by the ministry, will greatly facilitate effective and efficient implementation.

Responsibility for delivering the outcomes rests with the Ministry of Health and will call for strong human and financial resource planning and management, as well as thorough monitoring and evaluation to measure results. Tools have been developed to enable this process – a revised planning manual to facilitate better operational planning and budgeting, and three frameworks: for financial resourcing, for monitoring and evaluation, and for annual operational plans. Feedback mechanisms from consumers have been built in to ensure the pro-poor focus is realised.

Responsibility for the 6 areas of work has been assigned to lead departments and implementing units. Key to successful implementation are the critical success factors mentioned earlier and increased financial investment by the Royal Government of Cambodia and its partners.

Risks to successful implementation have been recognised. They include reduced government allocation to the health sector, reduced support from international partners, inadequate increases in professional staff salaries and health workforce resistance to management change.

This strategic plan is volume 1 of four volumes. Volume 2 is the medium term expenditure framework. Volume 3 is the sector monitoring and evaluation framework. Volume 4 contains the framework for annual operational plans to be developed by each budget management centre. There is also a short booklet that summarises the strategic plan. The booklet and all the volumes are available in both Khmer and English.

MISSION STATEMENT OF THE MINISTRY OF HEALTH, KINGDOM OF CAMBODIA

The Mission of the Ministry of Health, Royal Government of Cambodia is commitment to ensure sector wide equitable, quality health care for all the people of Cambodia through targeting resources, especially to the poor and to areas in greatest need.

VALUES OF THE MINISTRY OF HEALTH

- Right to health
- Equity
- Pro-poor

WORKING PRINCIPLES OF THE MINISTRY OF HEALTH

- Social protection for vulnerable groups
- Listening to what people want
- Affordability and sustainability
- Focus on rural areas and the poor
- Capacity building including human resource development
- Sector wide management
- High quality evidence based interventions
- Good governance and accountability

POLICY STATEMENT 2003 -2007

The policy statement of the Ministry of Health, Kingdom of Cambodia is based on the national health policy, which can be found in the booklet called 'Health Situation Analysis 1998 and Future Direction for Health Development 1999-2003'.

The following 13 elements that comprise the policy statement provide the basis for this strategic plan. The 20 strategies in the strategic plan flow from these elements.

- Implement sector wide management through a common vision and effective partnerships among all stakeholders
- Provision of basic health services to the people of Cambodia with the full involvement of the community
- Provision of affordable, essential specialised hospital services
- Decentralization and de-concentration of financial, planning and administrative functions within the health sector
- Priority emphasis on prevention and control of communicable and selected chronic and non-communicable diseases, on injury, the elderly, adolescents and vulnerable groups such as the poor, and on managing public health crises
- Priority emphasis on provision of good quality care to mother and child especially essential obstetric and paediatric care
- Active promotion of healthy lifestyles and health-seeking behaviour among the population
- Emphasis on quality, effective and efficient provision of health services by all health providers
- Optimisation of human resources through appropriate planning, management including deployment and capacity development within the health system
- Increase promotion of effective public and private partnerships for effective and efficient basic and specialist care
- Effective use of the health information for evidence-based planning, implementation, monitoring and evaluation in the health sector
- Implement health financing systems to promote equitable access to priority services especially by the poor
- Further development of appropriate health legislation to protect the health of providers and consumers

CHAPTER I: CONTEXT

Commitment to Global Goals and ASEAN Declaration

In box 1a are the relevant global 2001 millennium development goals for the health sector.

Box 1a. Global millennium development goals for achievement by 2015

- Halve, between 1990-2015, the proportion of people whose income is less than US\$ 1 a day
- Reduce by two thirds between 1990 and 2015 the under-five mortality rate
- Reduce by three quarters between 1990-2015 the ratio of maternal mortality
- Attain universal access to safe reliable contraceptive methods by 2015
- Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
- Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases

The above goals are highly ambitious for Cambodia given our extremely high levels of mortality and morbidity and poor resource base. So, Cambodia has set the health targets in box 1b to be achieved by the end of 2007, in other words within the time frame of this strategic plan. Achievement of the targets will contribute to reducing extreme poverty.

Box 1b. Millennium related development targets for achievement by Cambodia by 2007

- Reduce the proportion of under-weight children aged less than 5 years from 45% to 31%
- Reduce infant mortality from 95 to 84 deaths per 1,000 live births, and for under-five mortality from 125 to 111 deaths per 1,000 live births
- Reduce the ratio of maternal mortality from 437 to 305 deaths per 100,000 live births
- Increase modern contraceptive prevalence rate from 19% to 35% among women aged 15-49 years
- Reduce HIV infection rate from 2.8% to 2.1% among those aged 15-49 years
- Reduce incidence of malaria from 11% to 8%, and mortality from 10% to 7%

In 2002, together with its neighbours in the region, Cambodia signed up to the Association of South-East Asian Nations' Declaration (ASEAN) on Healthy Lifestyles which includes the following: "We envision by 2020 that health shall be at the centre of development and ASEAN cooperation in health shall be strengthened to ensure that our peoples are healthy in mind and body and living in harmony in safe environments."

National Constitution

The National Constitution of the Royal Government of Cambodia highlights political commitment to the goals stated above.

Article 31 of the National Constitution of 1993, and as amended in 1999, clearly affirm the recognition and respect for human rights including the rights of women and children, as stipulated in the United Nations Charter, the Universal Declaration of Human Rights, the Covenants, the Child Rights Convention and in related Conventions. The constitution states that all Khmer citizens shall have rights to obtain social security and other social benefits as determined by law. Both Articles 46 and 73 in the Constitution express that women, in particular those in rural areas and have inadequate social support, shall be provided with opportunities to get medical care in health facilities such as infirmaries and maternities.

More importantly, Article 72 of the National Constitution expresses clearly the responsibility of the Ministry of Health. It reads: “The health of the people shall be guaranteed. The State shall give full consideration to disease prevention and medical treatment. Poor citizens shall receive free medical consultation in public hospitals, infirmaries and maternities. The State shall establish infirmaries and maternities in rural areas”.

National policies and plans

Poverty alleviation is the main goal for the second cycle of the government’s socio-economic development plan. The plan aims to achieve equitable growth distribution, promote the accessibility of the poor to basic social services including health, education, credit, market opportunities and information, and to improve management of natural resources emphasising sustainable development.

In its poverty reduction strategy the government has proposed a ‘New Social Policy Agenda’ for Cambodia. The government plans to reduce poverty through promoting growth by investing in human capital to increase people’s capabilities and opportunities to contribute towards economic development. There is overall commitment towards improving access to health and education services especially for women and girls, and increasing participation and empowerment of the poor.

The public investment programme for 2001-2003 aims to ensure the success of both public health programs and the rehabilitation of basic health services. The areas of investment focus on strengthening health systems, priority health programs such as maternal and child health programmes, and the control of priority infectious diseases, strengthening hospitals and laboratories, and preparedness and response to emerging problems including the development of health education, primary health care and mental health. This health sector strategic plan provides the basis for the next cycle of the public investment programme.

Socio-economic environment

The long period of war and internal conflict, which started in 1970 and continued until 1993, severely de-stabilised Cambodian society, and created a deficit growth in the nation’s economy. The country’s economic recovery was further set back by domestic political upheaval in 1997 and the region’s financial crisis. Over 80% of the nation’s population resides in rural areas with poor access to basic services. More than 36% of Cambodians live below the poverty line and rural poverty accounts for almost 90% of total poverty.

Throughout the past 15 years, labour force participation of men and women has remained low reflecting the loss of human capital and skills as a result of the war. The majority of Cambodians have little or no education. Only 7% of men, and 4% of women have completed primary school, and at present, one in three women in Cambodia are illiterate.

There are major disparities in living standards between urban and rural areas. On average, only 17% of households in the country have electricity. The figure rises to 61% among urban households and drops to 9% in rural areas. During the dry season, almost 30% of the population gets their drinking water from open sources such as rivers, ponds or lakes and only one in five households has access to a latrine.

Box 2. Selected socio-economic indicators

• Total population (2001)	13.1 million
• Population projection (2011)	16.6 million
• Percentage of population in rural areas (1999)	80%
• Population below poverty line (1999)	36%
• Proportion of national poverty in rural areas (1999)	90%
• Gross domestic product per capita (2002)	US\$ 360
• Annual per capita income (1999)	US\$ 250
• Percentage of women who are illiterate*	32%
• Percentage of men completed primary school*	7%
• Percentage of women completed primary school*	4%
• Households in the country with access to electricity*	17%
• Percentage of households in rural areas with access to electricity*	9%
• Population who obtain drinking water from open sources during the dry season*	30%
• Households with latrines*	21%

*(2000)

The slow growth of the agro-based rural economy, the lack of improvement of farmers' incomes, and the more recent 'boom' of the textile industry have caused many young people to migrate to the capital city seeking employment as garment factory workers or in other manufacturing and service sectors. As a result, Phnom Penh has grown rapidly without corresponding development of its infrastructure. Around 25% of the city's population lives in slum areas without adequate water, sewerage or sanitation systems and has poor access to basic services. The population of Phnom Penh city is expected to double in 15 years signaling the need for some attention towards urban poverty and its health effects.

Urbanisation and the rapid change towards a free market economy have also resulted in changing lifestyles and risk factors among the middle and upper income brackets such as smoking, alcohol use, more sedentary work routines, less breast feeding due to aggressive marketing of breast milk substitutes, and possible changes in diet.

Post crisis (1979-onwards)

The civil war of the seventies and the ensuing political unrest during the past twenty years left Cambodia with a poor public sector infrastructure and services. The Khmer Rouge decimated the health system: of the 1,000 doctors trained prior to 1975, less than 50 survived the regime. In 1979, the restoration of a functioning health care system became one of the highest priorities of the new government of the People's Republic of Kampuchea.

The period 1980 to 1989 was one of reconstruction and rehabilitation, with many health workers being trained through accelerated training courses. The Faculty of Medicine, Dentistry and Pharmacy was one of the first educational training centres to be rebuilt by government and was opened early 1980.

The health service delivery system was set up as a socialist model and publicly financed, comprising Khum (commune) clinics, district hospitals, provincial and national hospitals based on administrative districts. All national programmes such as control of tuberculosis, malaria, dengue, diarrhoeal diseases and nutrition functioned vertically throughout the system.

Box 3. Post crisis related problems in the health sector

- Destruction of the physical infrastructure, and dismantling of professional and administrative cadres in the 70s
- Very high levels of mortality and morbidity
- Extremely high birth rate during the post-war period
- Distorted population pyramid, both in terms of sex and age
- Emotional, mental and physical trauma resulting from the war, including disabilities due to landmine accidents

The period 1989 to 1995 was a time of recovery with substantial government and donor investment. In 1993, the first Royal Government took office and authority and responsibility for programme development and budgetary control at local health units were transferred from local government to the Ministry of Health. Basic legislation on key organisations in the sector and regulations for the management of pharmaceuticals were prepared and laws passed between 1995 and 1998. In the 1990s, health staff started to augment their monthly government salaries of US\$ 10-15 by working in the private medical sector.

During the 1980s only UNICEF and a few other international non-governmental organization (NGOs) were active in Cambodia. Other external partners gradually started programmes or projects in the 1990s. From 1991 onwards the Ministry of Health re-examined its strategies and policies to focus on improving accessibility to health services in the rural areas. With support from the World Health Organization, in 1996, the health coverage plan was set up to establish a network of health centres and referral hospitals based on 'operational districts', a new version of health service jurisdiction areas demarcated by population distribution. The new system moved away from the original set-up of Khum clinics and district hospitals based on administrative districts.

In the mid-90s, international finance institutions such as the World Bank and the Asian Development Bank began contributing investment funds to develop rural health infrastructure, especially for civil works and strengthening of basic skills. During the same period, these institutions and many other international donors also started financing recurrent costs of health service delivery, the latter mostly through NGO assisted projects. A health financing charter introduced financial reforms to enable provincial and district health managers to access public and private funds to build and regulate their health systems.

CHAPTER 2: WHERE ARE WE NOW ?

Current health and demographic indicators

Box 4. Selected health and demographic indicators

• Life expectancy at birth (1998)	58.3 (females) 54.5 (males)
• Total fertility rate*	4.0
• Maternal mortality ratio*	437 deaths per 100,000 live births
• Infant mortality rate*	95 deaths per 1,000 live births
• Under-five mortality rate*	125 deaths per 1,000 live births
• Percentage of children under five years with stunting*	45%
• Percentage of children who are underweight*	45%
• Tuberculosis incidence rate (2001)	540 per 100,000 population
• Malaria incidence rate (2001)	8 per 1000 population
• HIV seroprevalence rate among 15-49 years*	2.8%

*(2000)

The 2000 Cambodian demographic and health survey provides the most recent estimates of priority indicators. The population structure reflects the impact of the Khmer Rouge regime between 1975 and 1979 during which mortality levels were high, particularly for men, and fertility levels decreased. In post-conflict times, a baby boom occurred to create a large proportion of people aged 20 years or less. This age group now comprises 55% of the total population.

Cambodia has experienced a period of fertility decline from 5.4 to 4.0 children per woman aged 15-49 years in the last ten years. The largest decline is in the capital city, Phnom Penh. However, it is notable that the hilly remote provinces of Mondulakiri and Ratanakiri show an increase in fertility levels over the same period.

About one in five Cambodian women who died in the seven years prior to 2000 did so from pregnancy or pregnancy-related causes. The maternal mortality ratio for the period of 1994-2000 is estimated at 437 deaths per 100,000 live births-an alarming figure.

Infant and under-five mortality rates signal a disturbing picture of child health in Cambodia. Almost one in every ten babies does not survive to his or her first birthday (95 infant deaths per 1,000 live births). Under-five mortality is 125 per 1,000 live births. Diarrhoeal diseases, acute respiratory infections and vaccine-preventable diseases cause about half of the under-five deaths. Over the past ten years, both infant and child mortality have steadily increased. The causes of this phenomenon need to be analysed more carefully. Post-neonatal mortality - currently estimated at 58 per 1,000 live births - has increased, constitutes the bulk (61%) of infant mortality and is a critical priority to be addressed.

Chronic malnutrition among Cambodian children is high, with 45% moderately stunted and more than one in five children severely stunted. The level of stunting increases with age from 15% among children less than six months to about 45% among children aged 3 years or older. Among children and women there is a high prevalence of micronutrient deficiencies, especially iron, and vitamin A, and iodine. Only 12% of households use iodised salt.

The burden of infectious diseases is heavy. The incidence rate of all forms of tuberculosis (TB) is estimated at 540 per 100,000 population, with a case fatality rate of 90 per 100,000. The number of new TB cases seen at public health facilities has trebled over the last decade. In 2001, the incidence of clinical malaria cases reached 8 per 1000 persons, with a case fatality rate of 9% among the severely ill.

The HIV epidemic seems to have reached its peak, and since 1999, the percentage of adult Cambodians who are infected with HIV has decreased from 3.2% to 2.8%. However, sero-surveillance and behavioural survey reports indicate that there is no room for complacency. By the year 2000, 169,000 persons have been estimated as infected with the virus, over 17,000 young people have died already from HIV infection, and over 8,000 cases of AIDS have been reported. Statistical projections imply that 7,000 children under 10 years of age have been orphaned by the epidemic and this number will grow to 48,000 by 2003. It is estimated that 74,000 adults and 16,700 children will have died as a result of HIV infection. The effects on the elderly are also grim: having lost their life's savings in the care and treatment of their children afflicted with AIDS they are often destitute and abandoned, perhaps with the burden of looking after orphaned grandchildren.

As in many other countries, the population aged 65 years or more is expected to increase resulting in a host of emerging chronic diseases such as cardio-vascular and renal disorders, cancer, and diabetes. Also, as commercial and industrial sectors expand, the health sector will also see increasing numbers of work-related injuries and road traffic accidents unless more attention is given to prevention.

Box 5. Health and demographic priorities to be addressed in the next five years

- The rise in infant and child mortality including increasing post-neonatal mortality, mortality and morbidity from diarrhoeal diseases, acute respiratory infections, vaccine-preventable diseases, dengue and malaria
- The high rates of under-nutrition among women and malnutrition among children
- High maternal mortality ratio, and deaths from obstetric trauma and septic abortions
- High case fatality from infectious diseases particularly HIV/AIDS, TB, and malaria
- The high total fertility rate
- Population growth
- Harmful practices among consumers and providers including unhealthy lifestyles and widespread inappropriate health seeking behaviour

The role and structure of the Ministry of Health

The role of the ministry at all levels is to give overall policy direction, regulate and legislate the sector, and develop, manage and finance public sector health systems and services.

The current organisational structure of the ministry is shown in Annex A1. At Annex A2 is the provincial organisational chart. The ministry currently comprises three directorates at the central level: health services, finance and administration, and inspection with the Minister of Health as chief executive. The activities of national hospitals, national programmes and national institutes are supposed to be coordinated by different technical departments of the ministry. However, in reality, they all report directly to the Director General of Health.

The structure, roles and functions are being reviewed as part of institutional strengthening related to this strategic plan. This review will be completed in the first year of implementation and will then become an ongoing process until 2007.

More recently in 2000, a private sector participation task force with representation from several key departments was formed to further develop strategies to improve participation and regulation of commercial and non-profit health providers and organisations.

At operational district level, health services are delivered within a framework of a minimum package of activities through health centers and a complementary package of activities for district referral hospitals and provincial hospitals. The provincial health department under the ministry's direction implements health policy and strategies through annual plans. Another main role of this department is to monitor and supervise operational district teams to ensure service delivery and effective utilisation of resources.

Since the mid-nineties, the ministry has established several mechanisms to coordinate and discuss sector-level issues with its partners. The coordinating committee (CoCom) and provincial coordinating committee (ProCoCom) were set up to coordinate inputs from international organisations, NGOs and donors at national and provincial levels. The CoCom provides the forum to promote dialogue and clear understanding of Ministry of Health priorities and has been used for debate and consultation on policy and strategy development. The ProCoCom is for provincial health department to coordinate and plan its work among all government, NGOs and other partners in each province according to specific needs, problems and priorities.

What is working well?

Some of the initiatives started in the mid-90s are now having positive outcomes. In this section we look at critical success factors upon which to better plan and build the future.

As stated earlier, during the early 1990s, the ministry launched a health sector planning and reform programme to reorganise the public sector health system and relocate facilities in order to improve accessibility especially in the rural areas. The expansion of basic health services has continued, 81% of the planned 940 health centres have been reconstructed or newly built and are providing the minimum package of activities to some extent. One positive impact is that attendance rates have increased, especially with regards to curative care contacts as well as antenatal care and birth spacing. But, overall attendance rates are still too low. The critical success factors for increasing rates include the availability of competent staff and medicines, budget access for recurrent costs and extension of services through outreach activities.

In 2001, Cambodia was declared polio-free. The ministry has now initiated programmes for eliminating neonatal tetanus and controlling measles. The reasons for the success in eradicating polio relate to strong commitment, active political participation at the highest level, technical and financial support from all partners, effective mass media campaigns and community participation. Active surveillance, careful planning, supervision and monitoring systems with timely and adequate provision of funds, vaccines and commodities also contributed to this achievement.

The observed reduction in the prevalence rate of HIV/AIDS among the adult population during the last years is another encouraging indicator. Although the Ministry of Health recognizes that partly this reduction is due to the increased number of deaths, the epidemiological and behavioural sentinel surveillance shows a reduction in the number of new infections among high risk groups and an improvement in the rate of condom utilization during commercial sex. These encouraging results are directly linked with the implementation of successful preventive interventions such as the 100% condom use programme.

Likewise, other services such as the directly observed treatment short course for tuberculosis (TB DOTS) are now extended to many new health centres, and the cure rate is being maintained at 85%.

Mortality from malaria has decreased and outbreaks are managed effectively. The critical success factors common to these two diseases include political commitment, effective intervention strategies as well as good multi-sectoral collaboration involving civil society, communities and other ministries.

Along with organizational reform, financial reforms are also in place to ensure the effective use of funds allocated to health. The Ministry of Health made a bold move in 1996 to levy official charges for services in order to regulate under-the-table payments and reduce household expenditures. Since 1997, household health expenditures have reduced from US\$ 29 to US\$ 24. Indirectly, self-regulatory measures and performance based contract management within facility teams have been effective in controlling unofficial payments. In connection, community linkages through Health Centre Management Committees and Village Health Support Groups formerly called Feedback Committees, have also contributed to regulating prices and promoting public health facilities and services.

Budgetary reform programmes such as accelerated district development (ADD), and the priority action programme (PAP) were introduced to increase access to the national budget resources for health systems development at district and provincial levels. To date public expenditures in these pilot areas have increased annually as a result of more flexible financing arrangements as well as political commitment to ensure budget access.

The ministry is better able to manage pharmaceutical supply systems. Expenditures on essential drugs and medical supplies have increased by 50% during the last three years and logistic management systems have improved at all levels. The strengthened management has mainly resulted from relevant, practical capacity building.

An innovative strategy of contracting health services to NGOs in very poor districts has recently been piloted with significant success in achieving dramatic increases of health service coverage and reducing of out-of-pocket expenditures. The critical success factors include the increase in financial resources from external sources, the injection of external management culture through non-governmental non-profit organisations and giving more authority to district health managers.

The partnership between the Ministry of Health and NGOs is strong and continues to be nurtured from both sides. Likewise, the ministry has good relationships with most external and international partners. Success factors in these partnerships includes actions by the ministry to initiate structures and processes to improve collaboration and coordination, and relevant technical, management and financial support.

Box 6. Critical success factors in the health sector

- Strong political commitment and good planning, supervision and monitoring systems at all levels of the health system for very specific cost-effective public health interventions
- Timely and adequate provision of funds and commodities
- Availability of essential drug supplies
- Adequate income for staff
- Active human resource management
- Extending services through outreach activities
- Mass media campaigns
- Community participation in health activities
- Flexible financing arrangements
- Regulatory measures through performance based contracting
- Partnerships with NGOs
- Appropriate technical, management and financial support from all partners

What are the key challenges ?

Health and population issues

The high rates of infant and child mortality are linked to poor coverage of critical child health services especially immunisation and poor access to and utilisation of trained providers for treatment of childhood illnesses, particularly for acute respiratory infections. The use of oral rehydration solution for children under five years of age with diarrhoea is fairly low. Also, exclusive breastfeeding for babies below five months of age is rarely practiced and there are also inappropriate complementary feeding practices. There is a high prevalence of micronutrient deficiencies. These all contribute to limited growth and development and reduced resistance to infection.

The coverage of maternal health services still remains low, especially for essential obstetric care. There is high unmet need for birth spacing and many women do not have access to safe abortion. The use of midwives, and availability of emergency obstetric care all need to be improved especially in remote areas.

Earlier in this strategic plan it was mentioned that there is a large proportion of people aged 20 years or less. This means that adolescent health is an emerging public health challenge. Of particular concern are the poverty related high rates of child/adolescent labour and the trafficking of young people, mainly for the sex trade.

The country still has large geographical areas that do not have access to cost-effective interventions that limit the high burden of infectious diseases. Such interventions are particularly needed to prevent and provide appropriate care and treatment for HIV/AIDS, TB, malaria, and dengue. Further efforts are required to continue building a well-functioning health system and to develop hospitals that can provide services at standard quality for many serious emergency conditions. Likewise, alternative strategies for targeting and extending access for example, through outreach, should be implemented as a priority to address the needs of the poor and socially disadvantaged.

There has been some success in the past in controlling and/or eradicating certain diseases. However, the vertical approach of many disease control programmes has not spread benefits throughout the system. Focusing on a single health problem has resulted in missed opportunities to address others of similar nature within the same target group calling for an alternative, more cost-effective approach to sustain the delivery of basic services.

Consumers and providers

Much more attention to behavioural change is required to improve the household health practices of consumers and carers with regards to nutrition, the use of preventive measures and healthy lifestyles. More efforts are needed to promote important behaviours such as immunisation, contraceptive use, breast-feeding, oral rehydration therapy, the use of trained providers for delivery and for treatment of childhood infections, and the means of protection against major infectious diseases such as condom use and bednets for vector control. A summary of priority health service interventions can be seen in box 12.

At all service delivery levels, poor communication between providers and consumers is a major obstacle in promoting family health. Poor quality within the public sector – from both professional as well as consumer perspectives - has deterred effective utilisation of basic health services. Limited resources, poor dissemination of clinical standards and limitations in technical as well as counseling skills has affected client trust in providers. It is prime time to sensitise providers on professional ethics and build their skills in interpersonal communication and counseling in order to build trust and empower consumers to make appropriate choices in adopting healthier lifestyles and practices.

Costs and sector financing

The price of health care is a major barrier to health service use especially at referral hospitals. The demographic and health survey of 2000 revealed that:

- On average, households spend almost US\$ 24 per capita on health services amounting to 9% of GDP;
- Among those who sought care, 80% had to use savings, or even borrow or sell assets to pay for health care costs.

Informal private sector providers such as drug sellers are the first source of care for the majority of consumers raising issues of poor quality and low effectiveness due to the lack of regulation. The ministry and its partners face challenges to limit the impoverishing effects of inappropriate health expenditures and enable equitable access to low-cost high impact services through targeting measures and innovative financing schemes.

The system suffers from limited staff availability and capacity especially in relation to midwives, nursing staff and others especially in peripheral areas. The difficulty in deploying and distributing adequate staff is partly due to recruitment procedures and the lack of identified posts and establishments needed for each health services resulting in mal-distribution of staff. Other issues related to staff distribution and motivation, particularly the lack of incentives or motivating factors especially for those who serve in remote areas. Training new staff and strengthening the skills of qualified people through continuing education is inadequate due to lack of trainers and financial resources.

The most critical factor that limits effective delivery of health services in the country is the low level of salaries for Ministry of Health staff which currently range between US\$ 15-30 per month. This low salary forces qualified personnel to devote their energies to private practice in order to earn a living wage. A key challenge in the next five years is to develop interim strategies that improve the income of government health staff in order to have a functioning health system especially in poor and remote areas, while broader public administrative reforms are being established. There is also need to strengthen regulation of private practice, i.e. practitioners and facilities and services in order to ensure quality and reduce malpractice.

The health sector is seriously under-funded at less than 1% of the country's gross domestic product through public sources. The government has attempted to increase access to the national budget through various fiscal and financial reforms. A new challenge will be to ensure that funds are allocated equitably, used effectively and that there is value for money. The national health budget has increased from almost US\$ 2 per capita in 1999 to US\$ 3 per capita in 2001. However, expenditures remain low and different budgetary reforms to improve access to funds are being piloted. The ministry needs to strengthen budget implementation including proper use of monitoring and financial auditing procedures.

Box 8. Summary of key challenges in the health sector

- Low utilisation of cost-effective public health interventions
- Poor attitudes and practices among service providers in communicating with consumers
- Mal-distribution of health service providers, especially trained midwives
- Poor quality of care in both public and private sectors
- The emerging public health issue of adolescent health
- High demand for family planning/birth spacing advice and commodities
- Low salaries of health staff in the public sector and lack of incentives to work in remote areas
- High prices, limited access to essential services among the poor, especially to referral hospitals
- Irregular and inadequate flow of funds to service delivery
- Poor management and leadership capacity, especially in monitoring, evaluation, supervision and for evidence-based, delegated decision making
- Inadequate capacity in human resource development including training and personnel management
- Limited coordination on external financing in the sector
- Managing major public health crises

Institutional challenges

Organisationally, the ministry encounters a lack of clarity about roles and functions within its departments and institutions and limited leadership linked to inadequate management skills. Partnerships among institutions at the central level as well as with field level departments have been quite rare. The challenge is to build institutional linkages for managing, coordinating and monitoring the implementation process in order to facilitate central departments, programmes, institutions and field personnel to interact closely and work as teams to produce common outcomes.

There is unnecessary duplication of resources, especially in terms of personnel and finances, when planning, training and supervision for different programmes are conducted independently and separately leading to lack of clarity within line management. It is important to start integrating service delivery and management systems at district level and upwards.

The Ministry of Health is committed to building collaboration and coordination processes with private providers for effective delivery of health services. The potential of private sector, including both for-profit and not-for-profit providers, will be harnessed to complement the provision of publicly funded services. At present, the ministry faces low capacity and unclear mechanisms to effectively monitor and regulate private providers through legislation and registration mechanisms.

Effective coordination with external partners is a priority. The mechanisms for consultation, collaboration and coordination are established for strategic technical issues, but less so for financial resources. The opportunity for the ministry to take the lead in consistently analysing health priorities in the sector, and deciding on resource allocation is often secondary to strategies and plans initiated by external partners. The development of this sector strategic plan is the first step for the ministry to increase the ministry's leadership in sector-wide management. The strategic plan highlights the ministry's new partnership approach towards working with donors and lending agencies in developing policy and in planning and financing the health sector in the country.

Managing public health crises is a major challenge. All societies need rescue, health and public health services to respond immediately and effectively to major disasters. The following three types of services are components of health protection:

- Monitoring and protection against communicable diseases
- Protection against non-communicable environmental hazards
- Planning for and response to emergencies

Typical events that the health system may have to respond to are floods, fires and various types of accidents, and major outbreaks of infectious diseases such as dengue or gastrointestinal disease. In disaster/emergency management the unexpected, unimaginable and unlikely also have to be considered. For example, major epidemic in animals that has implications for human health or an act of terrorism, such as a bomb blast or deliberate release of chemical or biological agents.

CHAPTER 3: STRATEGIC PLAN DIRECTION & SCOPE

What is new in this strategic plan for the health sector ?

For the first time we, in the Ministry of Health, Kingdom of Cambodia, have a sector wide strategic plan for all stakeholders. Sector wide and all stakeholders mean the private sector and partners as well as Ministry of Health employees and others. We would like everyone to work within the framework of this strategic plan and its desired outcomes. We call this approach sector wide management.

For the first time we have developed a mission statement, values and working principles, and a policy statement. We used them to guide our thinking during the process of determining the strategic plan and we hope everyone will use them when implementing the strategic plan.

For the first time six priority areas of work have been identified through a wide consultative process. These are health services delivery, behaviour change, quality improvement, human resource development, health financing, and institutional development. The six areas must be given high emphasis if we are to achieve, and maintain, a good reduction in those mortality and morbidity rates that are causing us greatest concern.

For the first time while the control of communicable diseases through cost-effective public health interventions remains crucial we are also paying more attention to chronic diseases and to other emerging public health issues in an attempt to reduce the burden of potential problems in the future.

For the first time health outcomes are given for the whole sector not just on an ad hoc basis in some programmes.

For the first time we have developed a strategic plan that is linked to the planning-budgeting cycle of the ministry and to a medium term expenditure framework. This will guide the use of resources during implementation.

Targets, goal and strategies

In box 1b are the millennium related development targets that the ministry has set for the period of this strategic plan. There are also some targets in annex C and in volume 3, the monitoring and evaluation framework. The following goal, strategies and outcomes are all linked to the targets. At Annex B, the strategic plan framework, you can see a summary of the strategies and desired outcomes, plus strategic actions. Detailed actions or activities will be developed at each level of the health system according to needs and problems, in annual operational plans.

Goal

The goal of the strategic plan can be seen in the box below. It is a guide to the general direction that all the strategies are leading towards.

Box 9. Goal of the strategic plan

Enhance health sector development in order to improve the health of the people of Cambodia, especially mothers and children, thereby contributing to poverty alleviation and socio-economic development.

Outcomes for the goal are:

- Reduced infant mortality rate
- Reduced child mortality rate
- Reduced maternal mortality ratio
- Improved nutritional status among children and women
- Reduced total fertility rate
- Reduced household health expenditure, especially among the poor
- More effective and efficient health system

Strategies within key areas of work

Key areas of work - The strategies result from a consultative process involving Ministry of Health policy makers and implementers together with partners and other stakeholders –see Annex E. During the process six areas of work were identified as needing to be given serious consideration during the period 2003 – 2007 if the health of the people of Cambodia is to improve. The areas are shown in box 10.

Box 10. Key areas of work

- Health service delivery
- Behavioural change
- Quality improvement
- Human resource development
- Health financing
- Institutional development

The six areas are listed in a conceptual logical order. Unless things change in how and where health services are delivered we will not succeed in reducing the seriously high levels of mortality and morbidity in the country, especially among mothers and children. Issues surrounding communication, lifestyle and quality are linked to the demand for, and use of, health services. Whatever is done over the next five years has major implications for human resources and for the financing of the health sector. Unless there are changes in the health sector as a whole, as an institution, then the chances of successful achievement of the intended outcomes are limited. During implementation health service delivery is top priority but all the other areas need to be considered as vital to each other and to health services. Therefore due weight should be given to each of the other areas depending on needs and problems at each level of the health system.

Strategies - There are 20 strategies and they have been grouped according to the key areas of work. The strategies are our priorities for the system as a whole and they reflect the values and principles of the ministry. While all the strategies are important there are 8 essential core strategies. These can be seen in box 11 below. The criteria for choosing these 8 were urgency, cost-effectiveness, and feasibility.

The strategies are a guide for resource allocation and for work at each level of the health system. Outcomes are given after the strategies for each subject area in the following pages in this chapter.

Box 11. The eight essential core strategies*Health service delivery*

- 1.** Further improve coverage and access to health services especially for the poor and other vulnerable groups through planning the location of health facilities.
- 2.** Strengthen the delivery of quality basic health services through health centers based upon minimum package of activities.
- 3.** Strengthen the delivery of quality care, especially for obstetric and paediatric care, in all hospitals through measures such as the complementary package of activities.

Behavioral change

- 4.** Change for the better the attitudes of health providers sector wide to effectively communicate with consumers especially regarding the needs of the poor through sensitisation and building interpersonal communication skills.

Quality improvement

- 5.** Introduce and develop a culture of quality in public health, service delivery and their management through the use of Ministry of Health quality standards.

Human resource development

- 6.** Increase the number of midwives through basic training and strengthen the capacity and skills of midwives already trained through continuing education.

Health financing

- 7.** Ensure regular and adequate flow of funds to the health sector especially for service delivery through advocacy to increase resources and strengthening financial management.

Institutional development

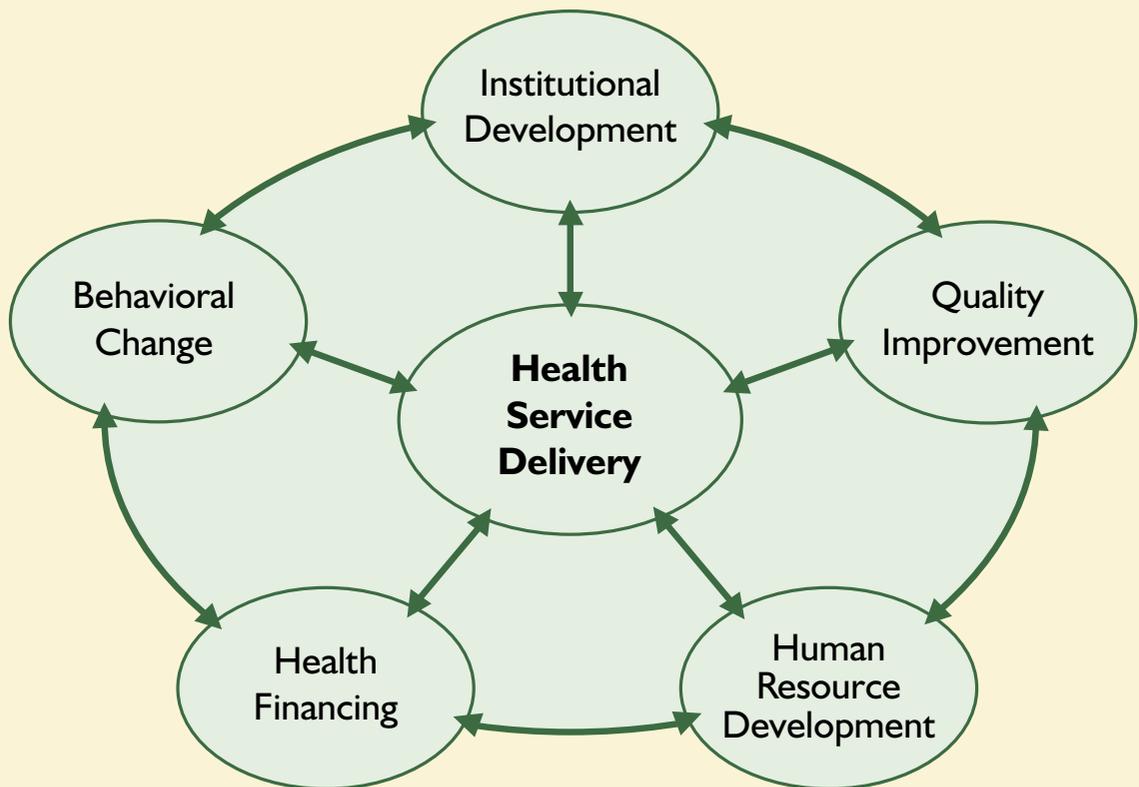
- 8.** Organizational and management reform of structures, systems and procedures in the Ministry of Health to respond effectively to change

Health service delivery

In the Ministry of Health we have made some impressive strides forward in our planning and implementation to address issues such as equity, accessibility and affordability of health services. But if we are to make a serious, sustained impact on reducing the extremely high levels of mortality and morbidity especially among poor people and particularly mothers and infants, and on having a healthier population by 2007, we need to do a lot more work sector-wide solving some priority issues in health service delivery. These include improving coverage and utilization, and health systems, integrating the national programmes especially at provincial level and below, implementing a quality based approach and evidence based interventions, and promoting both community and private sector participation in the planning and practice of health service delivery.

Health services therefore have a central place in this strategic plan and the other strategies can be seen in support of achieving health service delivery outcomes –see figure 1 below. This is right for this time in the country but may need to change in the next strategic plan 2008 onwards.

Figure 1. The central place of health services



During the process of developing the health service delivery strategies the ministry considered the matrix of essential services at annex C, priority health service interventions (see box 12 below), and issues such as the optimum mix of services, their location, and the most cost-effective options. The issues were explored through asking questions such as ‘what should we do more of, and better? what should we do less of, or stop? what should we start to do? what should we be doing differently and what should continue as before?’

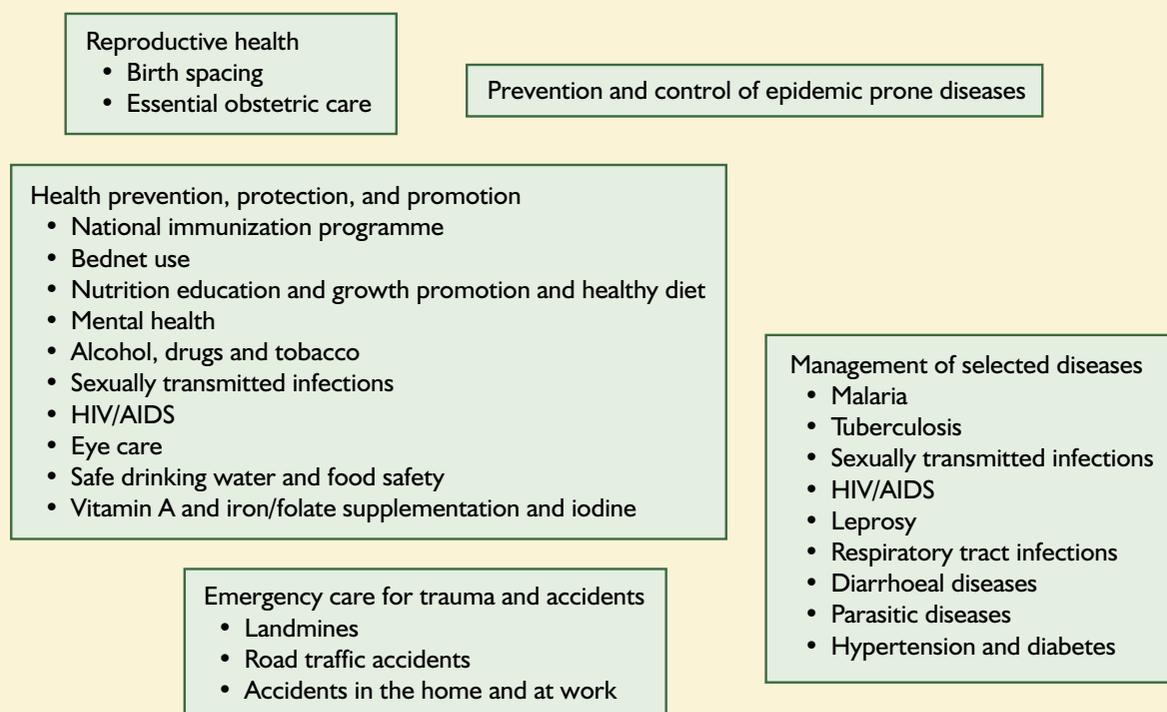
Strategies:

- Further improve coverage and access to health services especially for the poor and other vulnerable groups through planning the location of health facilities and strengthening outreach services.
- Strengthen the delivery of quality basic health services through health centers and outreach based upon minimum package of activities.
- Strengthen the delivery of quality care, especially obstetric and paediatric care, in all hospitals through measures such as the complementary package of activities.
- Strengthen the management of cost-effective interventions to control communicable diseases.
- Strengthen the management and coverage of support services such as laboratory, blood safety, referral, pharmaceuticals, equipment and other medical supplies and maintenance of facilities and transport.

Outcomes:

- Improved coverage
- Increased utilisation of preventive and curative services especially by the poor
- Reduction of prevalence rates of communicable diseases
- Increased availability of supplies and functioning equipment
- Effective referral system

Box 12. Priority health service interventions*



*See annex C for the choice of cost-effective interventions

Behavioural change

We need to enable consumers to have information that will allow them to make decisions about what they will do to have better health for their families and themselves, for example, start early breastfeeding, never start smoking, or the benefits of knowing one's HIV status.

It is widely acknowledged that while some health care providers are excellent communicators with their clients overall the health sector has a weak reputation for responsiveness to consumer needs, especially of the poor. This may partly account for the predominance of relying on private sector care resulting in low utilization of cost effective public health interventions in the public sector. While simultaneously improving quality of care we need to both enhance the capacity of providers to be more responsive to, and communicate better with, consumers and empower consumers to have a say on what is done, how, and when, in the provision of care.

In the Ministry of Health we have put a lot of effort into strategies for saving lives and treating acute conditions, particularly related to communicable diseases, since the end of the war. This work needs to continue because mortality rates for women and children are still very high. But there now needs to be a major effort to promote healthy lifestyles so that we prevent a high burden of chronic conditions such as cancer, diabetes, cardiovascular disease, and depression. And to address other emerging public health issues such as road traffic accidents and substance abuse.

The prevention of a rise in chronic conditions cannot be addressed just by the actions of the Ministry of Health. Interministerial collaboration is crucial, for example on legislative and policy development on healthy environments, and on tobacco advertising.

Strategies:

- Change for the better the attitudes of health providers sector wide to effectively communicate with consumers, especially regarding the needs of the poor, through sensitisation and building interpersonal communication skills.
- Empower consumers, especially women, to interact with other stakeholders in the development of quality health services through mass media and inter-personal communication.
- Promote healthy lifestyles and appropriate health seeking behavior through advocating for healthy environments and implementing counselling and behavioural change activities.

Outcome:

- Appropriate practices and healthy lifestyles as a result of informed decisions, especially by women

Quality improvement

There has been much talk over the past few years on the need to improve various aspects of quality. Some work has been done but it has been patchy.

We want to achieve quality of prevention and care for consumers, quality of life and health improvements for the population, and quality management.

This is a huge agenda of work including service delivery and behaviour change, as it means addressing equity, accessibility, effectiveness, efficiency, appropriateness and responsiveness. So for this strategic plan we have developed two top priorities. These are covered in the following strategies.

Strategies:

- Introduce and develop a culture of quality in public health, service delivery and their management through the use of Ministry of Health quality standards.
- Develop and implement minimum and optimum quality standards for the public and private sectors incorporating pro-poor and gender issues through the use of appropriate tools.

Outcome:

- Institutionalised capacity in the health sector for quality improvement and assurance is developed and a culture of quality management grows within the country
- Improved quality of health services sector wide

Human resource development

In this strategic plan human resource development is all about planning the workforce, managing it, and training and educating people. There is some excellent capacity and relevant skills among some of our workforce. However, we need to ensure that by 2007 this statement reads 'There is excellent capacity and relevant skills among all our workforce'. Because the environment in which we are living and working is constantly changing we need to ensure that there is an ongoing process that enables everyone to gain new technical information and acquire the ability to do new things and existing things differently. Both basic and continuing education in health need to reflect this. We also need to ensure that our workforce feels it is important to the Ministry and country.

Furthermore, if we are to successfully address the high mortality and morbidity rates and promote a healthier population we need to better ensure that the right staff are in the right place, in the right numbers, at the right time, with the right skills and attitudes.

Strategies:

- Increase the number of midwives through quality basic training and strengthen the capacity and skills of midwives already trained through quality continuing education.
- Strengthen human resource planning to reduce mal-distribution of the numbers and type of workforce through identification of posts and the reallocation of staff.
- Enhance the management and technical skills and competence of all Ministry of Health workforce through quality, comprehensive training, education, retention and support measures.

Outcomes:

- Better essential obstetric care
- Improved performance and distribution of health staff
- Improved management and technical skills of health staff throughout the sector
- Effective management of health personnel

Health financing

We have a sound policy framework for financing. But this policy has to be understood within the context of a sector that is under-funded and suffers from poor access to pledged/agreed allocations. Furthermore, one of our biggest challenges is to make sure that the financial contributions that people make to the health sector in the form of fees are fair and give value for money, especially for the poor. Various financing schemes are being tested including official user-fees and boosting strategies.

Fundamental to the success of any scheme to ensure fairness of financial contribution is sound accounting and audit. To make the best use of our limited resources we must also work towards more transparent, effective and efficient health expenditures. All these management issues are achievable. The biggest threat to doing so is the continuing low salary levels of our workforce.

Strategies:

- Ensure regular and adequate flow of funds to the health sector especially for service delivery through advocacy to increase resources and strengthening financial management.
- Allocate financial resources to improve the accessibility of health services for the poor through alternative health financing schemes.
- Ensure transparent, efficient and effective health expenditures through strengthening resource allocation, coordination of different sources of funding, and monitoring.

Outcomes:

- Improved total public expenditure from internal and external sources
- Improved regularity and adequacy of funding flow to health
- Increased cost-effectiveness, and efficiency of health service delivery systems
- Reduced financial barriers to access to hospital services for the poor
- Improved transparency in management of funds

Institutional development

The health sector is under much pressure. Mortality and morbidity are very high, staff are poorly motivated, and resources limited. The role of the Ministry of Health is also undergoing change as concepts such as sector wide management are developed. The scale of institutional strengthening needed to address these and other issues is considerable. A major shift is required from a bureaucratic style based on civil service practices to a more flexible and creative managerial culture if significant change is to be achieved.

The implications of the stress on managers of their current work and managing change are daunting. Work or actions therefore in the first year will be limited to ensuring clarity about roles and functions and development of leadership and management skills at all levels of the sector and particularly the central level.

As an institution, the ministry not only needs more effective and efficient management but also, on the technical side, to give much greater attention to chronic diseases and health lifestyles. These pose public health and economic threats to our country. We need to both manage chronic conditions better and have an increased emphasis on prevention to reduce their impact. We will develop comprehensive plans for priority chronic diseases that address prevention, screening, treatment, palliative care and rehabilitation. We will also have plans for other emerging public health problems such as injuries and substance abuse.

Strategies:

- Organisational and management reform of management structures, systems and procedures in the Ministry of Health to respond effectively to change.
- Effective public private partnership to improve accessibility, quality and affordability through the promotion of private sector participation and enforcement of regulations.
- Enhance Ministry of Health capacity to address chronic and other non-communicable diseases and emerging public health problems through raising awareness and developing comprehensive plans.
- Further develop the health sector to strengthen management effectiveness throughout the health service by:
 - a) Enhancing management and leadership culture sector-wide
 - b) Increasing effective decentralization and deconcentration
 - c) Institutionalising sector wide management

Outcomes:

- Increased efficiency, effectiveness, and accountability of the ministry at all levels
- Laws are appropriate and fully enforced
- Improved supervision and regulation of private services
- Increased participation of private sector in health service delivery
- Increased public awareness on prevention of chronic diseases
- Effective and efficient approach to sector wide management through joint planning, monitoring and evaluation
- Improved accountability and effectiveness of the health system
- Improved stewardship of the sector by the Ministry of Health

Risks and assumptions

In the real world things sometimes happen that can seriously hinder the successful achievement of the best written plans. Through asking ‘what if...?’ time and time again the ministry concluded that the risks in Box 13 below are the most important ones. We have considered the risks during the development of this strategic plan and to the extent possible we also need to monitor, minimise and manage them during implementation.

While developing the strategies the ministry also listed the assumptions against which they were set – also in box 13. These assumptions will be an important part of the implementation monitoring and evaluation process to see the rate of progress towards achievement of the outcomes we are aiming for.

Box 13. Risks and assumptions

Risks:

- Poor macroeconomic growth reducing government allocation to health sector
- Interruption of support from international agencies as a result of changes in their policies or because of political instability
- Forthcoming elections and potential for political instability
- Resistance to change within the Ministry of Health and overall government especially concerning human and financial resource management
- Salaries of the health workforce do not rise sufficiently
- Not enough attention to health promotion and changing health and health seeking behaviour
- No change in the way that vertical programmes operate resulting in provincial implementers having limited opportunity for change management or doing things differently
- No improvement in quality of care

Assumptions:

- Continuing and accelerating economic growth
- Continuing stability of the political situation in the country
- Willingness to reform the Ministry of Health to respond to changing health system needs
- Continuity of resource availability (domestic and international)
- Increasing transparency about income and expenditures
- Increasing transparency and performance and needs-based human resource management

Overall, the strategic plan:

- Reflects the need to think creatively if we are going to be even more successful in the future.
- Highlights pro-poor interventions.
- Has strategies and outcomes that link the targets in box 1b, to the policy statement, the priority problem indicators in box 4, the health and disease priorities in box 5, and the key areas of work in box 10.
- Takes an incremental approach to change. There is no sudden, surprise big change to be introduced immediately.
- Is not prescriptive. It allows for flexibility at different layers of the health system.
- Recognises that improving the health status of the people of Cambodia depends not only on actions within the health sector, but also on factors outside the sector.

CHAPTER 4: IMPLEMENTATION ISSUES

This chapter outlines the process to operationalise the various strategies, i.e. planning annual programme activities, deciding on resource allocation, arrangements to finance the implementation process and the monitoring and evaluation of programme performance. As the strategic plan underpins a common vision for all stakeholders in the sector, building partnerships is of critical importance and the last section indicates plans to achieve this.

Implications for ways of working, for resources, and for legislation

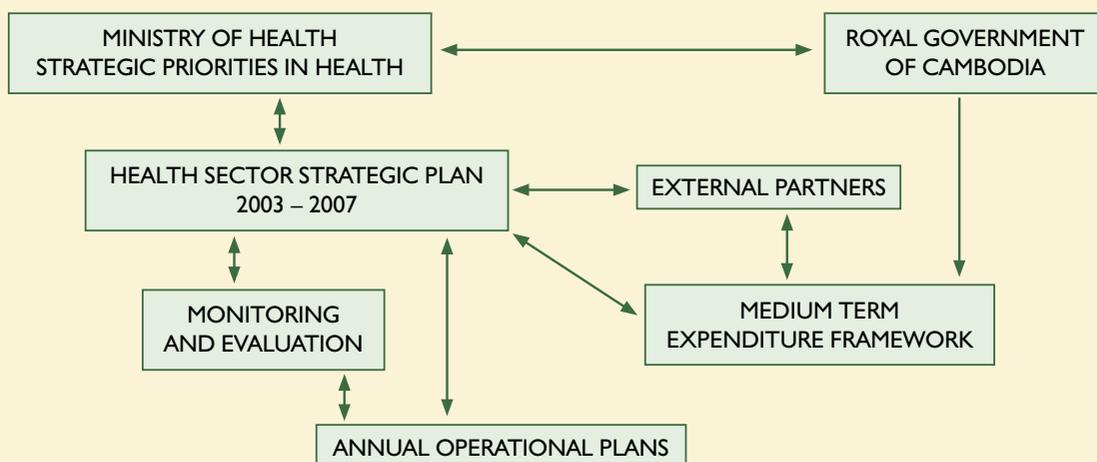
There are a number of implications of this strategic plan. The key ones are the need for:

- The values and working principles of the Ministry of Health to be really adopted by all stakeholders, that they are not just rhetoric
- Continued emphasis on systems development and capacity building
- Emphasis on creating competence for the management of change and organizational development
- Increased delegation and capacity to manage effectively and efficiently at delegated levels
- Increased decentralization and deconcentration
- Linking planning with need and with health financing
- Integration of national health programmes at the operational district level
- Partners to work within the framework of the strategies and their desired outcomes
- Systematic and regular monitoring and evaluation using appropriate health, management and financial indicators
- Additional resources for some of the strategies, so some work will have to be phased in as resources become available
- Ensuring consistency between legislation and Ministry of Health and other health related policies and their effective implementation
- Emphasis on health outcomes for the population

The implementation of the strategic plan is a challenge for all stakeholders, the government, all levels of the ministry, private sector providers, the consumers and external partners.

The diagram below shows how the strategic plan leads to the development of implementation or operational plans under new arrangements within the planning cycle. The operational plans will also be scaled to match available funding detailed in the medium-term expenditure framework that draws together resources from a variety of origins. Performance is measured against the strategic plan and the local level based annual plans, through an ongoing monitoring and evaluation process.

Figure 2. The strategic planning & implementation process



Implications for change management during implementation

To make a move from strategic plan to implementation, responsibilities for the strategies within the key areas of work have been assigned to lead departments and implementing units according to currently defined budget management centres (see Annex B). We need to keep working together as we have done during the design phase, to ensure issues are raised and ideas flow bottom up to feed into strategic decisions. This calls for coordination structures and processes that enable staff at the periphery to participate in decisions that affect sector-wide priorities.

Support from central level to provincial planning and implementation is essential and mechanisms such as coordination will help identify responsibilities from both levels to ensure joint accountability in achieving planned outcomes. Ownership of strategy implementation has to be with line managers at all levels, as it is they who will make most things happen, hence the emphasis on building management capacity including leadership skills. At present, those with operational responsibility have limited authority for expenditures. As part of moving towards effective decentralisation, the devolution of authority will be mapped out particularly for financial decisions.

The period 2003-2007 also calls for closer working relationships between the central ministry's Department of Planning and the Department of Budget and Finance, particularly to integrate planning and budgeting, and to monitor expenditures against activities and to validate reported expenditures and outputs, i.e. through performance budgeting and performance audits. Likewise, closer linkages between the Personnel Department and Human Resource Development Department are also envisaged.

Another key task is to support the planning process of some lead central level departments and programmes as their roles and contribution to the sector becomes more clear with the strategic direction for the next five years. There is a critical need for institutional measures that strengthen teamwork at all levels.

Financing the strategic plan

The strategic plan comprises many components that will be funded by the government and different agencies through technical and financial assistance. Several mechanisms will be used including through the national budget, loans, grants and donor budgetary support. External financing for this strategic plan 2003-2007 will not be pooled and funds will be targeted to specific actions or activities featured in the strategic framework.

The medium term expenditure framework will be the key financial plan for the sector indicating planned expenditures for major actions/activities against implementing units, i.e. the budget management centers (see volume 2). The framework—also a requirement to support larger government financial reform strategies - will present resource needs estimated through cost projections of planned activities and financial allocations based on the current resource envelope. Projecting the resource envelope for the later part of the strategic plan cycle will be less accurate as government and donor financing flows are contingent on many external factors and subject to changes in priorities. The spending limits for this period will be indicative and updated annually as expenditures are monitored and information on resource availability becomes more precise throughout the planning cycle. The medium term expenditure framework will indicate shortfalls and duplications against major activities that would enable the government and its partners to plan jointly and allocate resources more efficiently.

The institutional process of monitoring expenditures and making informed decisions indicate the need to strengthen the capacity of the central ministry as well as provincial and district staff in financial management.

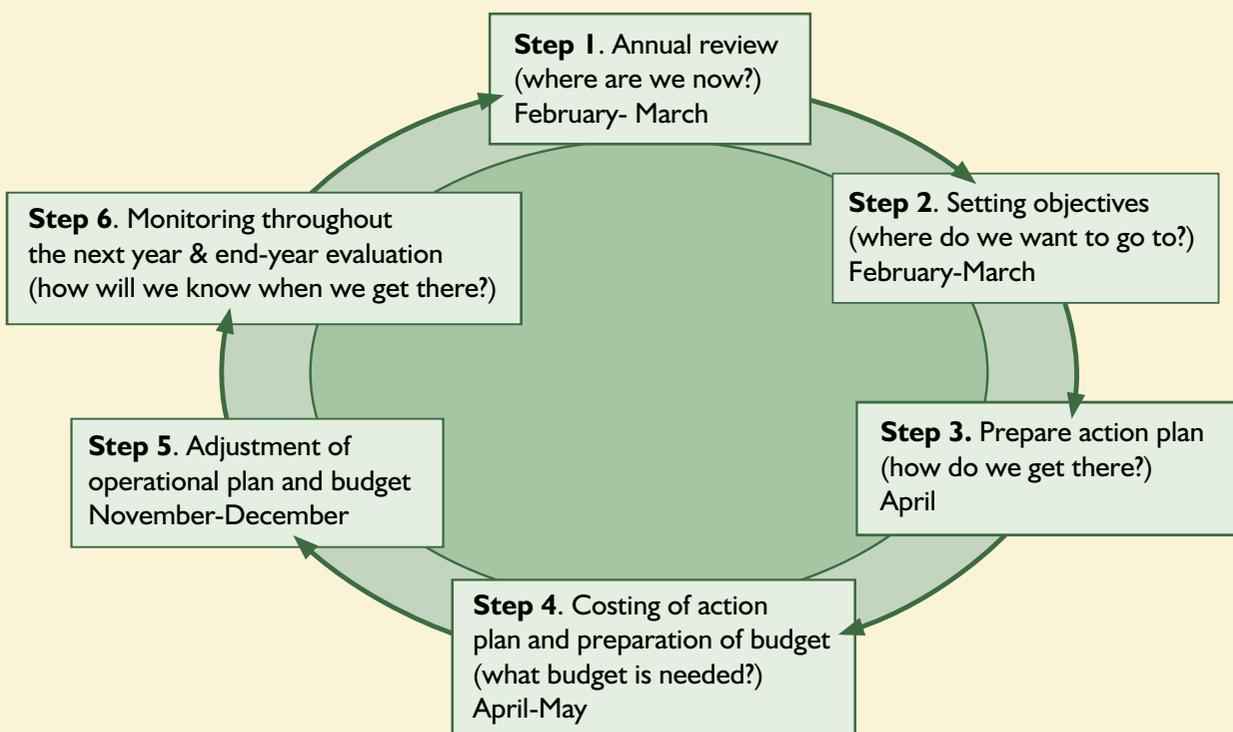
Planning-budgeting process

To date, there have been limitations to effectively link planning and financing as the budgeting cycle precedes provincial planning timetables to meet the time lines for budget negotiations and resource allocation decisions with the Ministry of Economy and Finance. Also, unpredictability about being able to access allocated funds had created uncertainty in implementing planned activities, which has led peripheral staff to produce ambiguous operational plans. For the period of 2003-2007, a new process will be put in place where strategic priorities will provide a basis for annual plans, and those plans will be costed and budgeted based on a resource envelope that includes both government and external funds.

During the period of 2003-2007, the ministry will integrate planning, budgeting and monitoring at the level of budget management centers. In 2003, implementation of this integrated planning approach will be piloted in three provinces. The remaining 21 provinces will follow the previous planning cycle but all provinces will incorporate the priorities of the strategic plan. The 2003 planning cycle will follow the new approach of integrated planning and budgeting. Hopefully, 2004 will be the first year that all budget management centers will produce operational plans linked to budgets.

National strategies will be incorporated into annual operational plans of the central and provincial health departments indicating actions/activities by time lines and their estimated budgetary needs. In order to accomplish this, the current planning process at the provincial and district level will assume a three-year rolling process that starts mid-financial year by reviewing progress made in the past year, and identifying priority actions or activities for the next year. Such work will be costed and correspondingly, financial allocations will be indicated based on the available resource envelope and established expenditure guidelines.

Figure 3. Revised Ministry of Health planning cycle, 2002



Note:

- By May-June provinces will submit next year's action plan and budget (Annual Operational Plan) to the MoH.
- The MoH Planning and Finance Departments will review action plans and budget, provide feedback, and if necessary suggest to revise action plan and/or budget.

Planning-budgeting tools

The ministry has several tools to help the planning and budgeting process including a:

- Framework for operational planning at central and provincial level highlighting a new planning cycle, and the steps in defining objectives and targets based on strategic priorities (volume 4)
- Planning manual that indicates the process for incorporating national level priorities into annual operational plans and corresponding budget estimates at the provincial level
- Monitoring tools, including health and financial information systems that indicate programme outputs and their corresponding expenditures

The operational plans developed by budget management centres should include objectives for all government and externally financed work, within the framework of the strategies in this strategic plan. The operational plans should meet requirements for preparation of the annual budget of the Ministry of Health. Thus, the planning process for 2003-2007 will gradually merge to be in line with the government's budget cycle and the overall agreed allocation to the health sector. By mid-strategic plan period, it is envisaged that the annual plans will be results-based and monitored to improve accountability of public sector health expenditures. At the end of each year, as part of the sector wide management approach, the ministry and its partners will review progress with implementing operational plans and expenditures.

It is vital that the operational plans clearly define measurable outcomes and outputs that can be monitored. Overarching assumptions and risks will again be considered during the development of operational plans including the analysis of local situations concerning the willingness and support from partners, i.e. local authorities, other ministries and external partners.

Bottom-up approach and integration

A bottom-up approach is a key guiding principle for this planning-budgeting process. The planning process will start with district level plans that will merge into provincial plans that relate national priorities to work at the local level. The Planning Department of the Ministry of Health will take the lead role in guiding the development, and quality control of plans from both the central and provincial level. Proposed plans and budgets will be assessed by both the Department of Planning and the Department of Budget and Finance who will then make joint decisions to allocate financial resources against activities.

Stakeholder consultation is valued and representatives from other government and non-governmental agencies, commune council representatives, consumer representatives such as village health support groups will participate in identifying priorities. Their participation will later extend to joint monitoring at the field level.

Efforts will also be made to integrate the operational plans of national programmes into provincial plans. Coordinating with the Planning Department, each programme will convey national level objectives and targets to the provincial health departments before the operational district planning process starts, who will then translate them into provincial targets and activities. All programme activities, including training, supervision, special campaigns, with the exception of epidemic outbreak responses, will be integrated into the provincial planning cycle.

New work and its implications for planning

New work in health service delivery is mostly around the revision and completion of the health coverage plan and standardisation such as for the minimum and complementary packages of activities.

For behaviour change the new work is challenging and includes developing and implementing a national policy on information, education and communication/behaviour change focusing on coordination, quality standards, dissemination of relevant materials and training, using the mass media and inter-personal communications skills to encourage consumers to adopt appropriate health seeking behaviour and use quality health services, and standardising procedures and coordinating monitoring and evaluating systems to measure behaviour change among providers and consumers.

Most of the new work is in the area of institutional development and in quality improvement. For institutional development, actions needing to be implemented in this five year strategic plan are closely related to strengthening management and leadership in the Ministry of Health and working towards excellent collaboration and coordination with partners to ensure effective use of available resources, both internal and external.

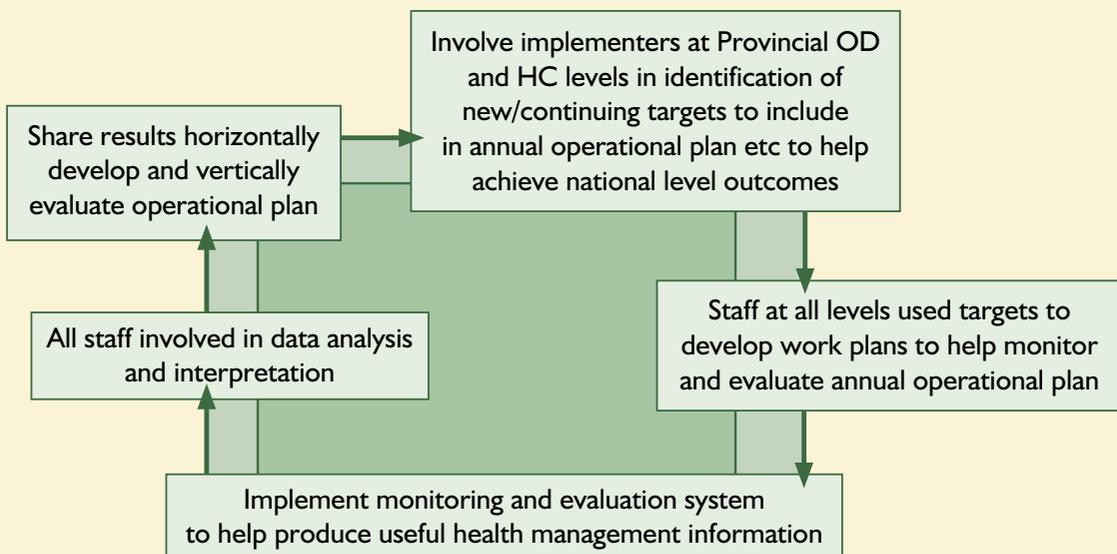
Quality improvement is another area in which new work should mostly be started in years one and two. The actions focus mainly on developing a quality culture throughout the sector by implementing quality standards, quality seal and awards for quality.

Within the area of human resource development, the focus of the work in years one and two is on ensuring the appropriate quantity and quality of staff in particular midwives.

Monitoring and evaluation process

There is critical need to build capacity for monitoring and evaluation at all levels. The Planning Department of the central Ministry of Health will take the lead in providing technical support and coordinate with all other departments and programmes in the monitoring process. The monitoring and evaluation system will also weave in field audit activities on verifying service output indicators as well as expenditures according to plan activities. Efforts will be made to discuss achievements and shortcomings with providers, managers and stakeholders at the field level to provide feedback and incorporate monitoring data into the planning and decision-making process. At sector level, findings from monitoring and evaluation will be incorporated into further planning, decision-making and resource allocation actions.

Figure 4. Ministry of Health monitoring and evaluation cycle, 2002



All levels of the health system need to incorporate the 20 strategies given in the health sector strategic plan 2003-2007 into their monitoring and evaluation work. To help with this the Ministry of Health:

- Has developed a matrix for use by provincial level, central level departments and health facilities (see Volume 3). This gives the 20 strategies with columns for activities, planned outputs, targets, indicators and means of verification. The latter should mainly be routinely collected information. To allow for differences between provinces in particular and to encourage flexibility the columns have not been filled in by central level Ministry of Health. They are open for stakeholders to fill in as appropriate.
- Has also developed a matrix for use by central level Ministry of Health that gives outcomes instead of targets, and the indicators include equity and poverty related ones (see volume 3). The targets set by others should contribute to achieving the outcomes. The means of verification includes surveys and reviews.
- Would like all partners to use the ministry's management information subsystems to save both time and money by not creating duplicative systems of information for separate project, programmes or institutional requirements (see examples of subsystems in following box).

Management health information subsystems applied both in the private and public sectors

- Epidemiological surveillance
- Services within health facilities
- Referral
- Human resource development
- Financial management
- Institutional management
- Facilities management
- Logistics management

- Is encouraging the development of a monitoring and evaluation process or approach that is seen as useful by implementers, allows accountability and transparency, and is efficient and effective.

In the near future the monitoring and evaluation system will have four core components:

- A revised version of the health information routine reporting system linked to the existing systems but emphasising sector wide management issues
- Routine service delivery studies
- An extended financial reporting system
- A limited number of knowledge, attitude and practice surveys of households

The working principle of the monitoring and evaluation process is based on linking indicators to implementation progress and financial allocations. The scale of actions includes developing a bottom-up system that brings in field level indicators to be compiled for a summary of progress at sector level. The following scope of work is envisaged:

- Routine monitoring through monthly, quarterly and annual reports on activities, plan outputs and expenditures from 2003 onwards
- Annual sector level performance reviews on outcome indicators and the implementation and expenditures of major activities
- Mid-term evaluation early 2005 to review strategic plan performance at the sector level
- Final evaluation through an overall sector review and a national health survey in 2006.

The overall impact of this strategic plan will be evaluated at the sector level through the following categories of indicators:

- Improvement in health outcomes including health status, healthy lifestyles and behaviour of the population especially among the poor and socially disadvantaged
- Reduction in household health expenditures with particular reference to the poor
- Improvement of the capacity of the Ministry of Health on institutional and other management change

At the outcome level, the following groups of indicators will be monitored as corresponding to the 6 key areas of work:

- Access to, utilisation and coverage of health services especially among the poor and remote areas of the country
- Improvement in quality of health services in both public and private sectors
- Adoption of appropriate health seeking behaviour and healthy lifestyles among the population
- Improvement in responsiveness and skills of health providers sector-wide
- Wider interaction between providers and consumers at all levels
- Increased levels of funding to health service delivery
- Improvement in leadership and management capacity sector-wide at all levels

Where appropriate, indicators will be disaggregated to urban/rural location, region and gender, to the extent permitted by data availability. The outcomes for the strategic plan were given earlier in Chapter 3 and are also in Annex B. In Volume 3, the monitoring and evaluation framework is information about indicators of achievement of the outcomes, and the means of verification of the indicators.

At the output level, on an annual basis, the government and partners will jointly review the operational plans and budgets, their implementation and expenditures. The progress with major work and the level of support channeled for implementation in terms of technical and financial assistance will be monitored through the management information system and the medium term expenditure framework.

The performance indicators and interpretations of the outcomes will be disseminated widely using existing structures such as the Annual Health Congress and the coordinating committees of the ministry. The issues raised will feed into joint decisions and strategic planning process in the health sector.

Other management issues

Some other important implementation management issues can be seen in box 14, two pages further.

Consumer consultation

It is critical to build in mechanisms to obtain feedback from consumers, particularly to ensure the pro-poor approach of the strategic plan. Existing structures such as Village Health Support Groups will be used to collect information on preferences and opinions on service delivery strategies, quality and affordability.

It will also be important to assess consumer perspectives systematically country wide to feed into national level strategies and plans. Qualitative and/or quantitative customer surveys, with appropriate sampling to ensure representation of the poor and socially disadvantaged, will be spaced at mid and end cycle periods to inform whether intended outcomes are being achieved. The results will then be channeled through the monitoring and evaluation system to be incorporated into further planning and decision-making.

Building partnerships within government and local non-governmental sectors

Linkages within government, i.e. inter-sectorally are also valued and the ministry is strengthening these as a priority mainly through the sector wide management process. The prime areas for building institutional linkages with other ministries include the following:

- For planning and financing - with the Ministry of Planning and the Ministry of Economy and Finance
- For mother and child health - with the Ministries of Education, Youth and Sports; Women and Veterans' Affairs; Social Affairs, Labour and Youth Rehabilitation; Information; and Rural Development
- For environmental health and the control of important infectious diseases such as malaria and HIV/AIDS - with the Ministries of Education Youth and Sports; Information; Interior; Defence; Environment; Industry, Mines and Energy; Agriculture, Forestries and Fisheries; Culture and Fine Arts; Culture and Religious Affairs; Tourism; and Rural Development.
Also the National AIDS Authority.
- For advocacy and other work about issues such as controlling the marketing of breast milk substitutes, and tobacco-related and other legislation, taxation and revenue implications - with the Ministry of Interior in particularly local authorities, and the Ministries of Information; and of Commerce.

Likewise, closer interaction between the Ministry of Health with professional associations, local NGOs and private for-profit sector organisations are also encouraged to bring in opportunities that are mutually supportive and lead to overall improvement of the health of the population.

Partnerships with external agencies

The key areas for building partnerships through the strategic plan are:

- Planning for priority actions and channeling technical and financial support
- Coordination to monitor and track progress with implementation
- Decisions on resource allocation for efficiency, reduced duplications, gaps and shortfalls in financing

Sector-wide management highlights the role of the Ministry of Health in proactively leading the process on the above work. Some tools that enable the ministry to accomplish the three activities are:

- This health sector strategic plan 2003-2007 states a common vision, strategies and outcomes for all partners as a guide to their inputs to the sector (volume 1)
- The medium term expenditure framework indicates support from different partners to specific components and activities in the strategic plan that helps in coordinating sector financing for more efficient results (volume 2)
- The monitoring and evaluation framework outlines agreed outcomes and provides the basis for joint reviews and performance monitoring (volume 3)

Several mechanisms are in place to facilitate coordination, of which the ministry's coordinating committee (CoCom) is the central forum for reporting, discussion and coordination among partners. The CoCom encourages debate on policy and strategic approaches and the membership includes all major partners including donors, technical assistance agencies, international organisations and non-governmental organisations. As and when needed, special CoCom meetings are held to review and discuss progress and map out further work. The terms of reference of the CoCom were revised early 2002 to encourage discussions on issues related to this strategic plan and efforts being taken to strengthen its effectiveness as a forum for policy debate.

At the provincial level, the provincial coordinating committee (ProCoComs) meetings provide opportunities

to coordinate and monitor health work being planned and implemented by government, local authorities, NGOs and others.

Other venues for sharing information include the regular meetings of MEDICAM (the lead coordinating agency for NGOs active in the health sector in Cambodia) and a monthly meeting among external partners coordinated by the World Health Organisation Office in Phnom Penh. The latter presently serves as a venue for open discussion among external agencies. However, as partner coordination improves it will be important to merge the meeting into CoCom by end 2003.

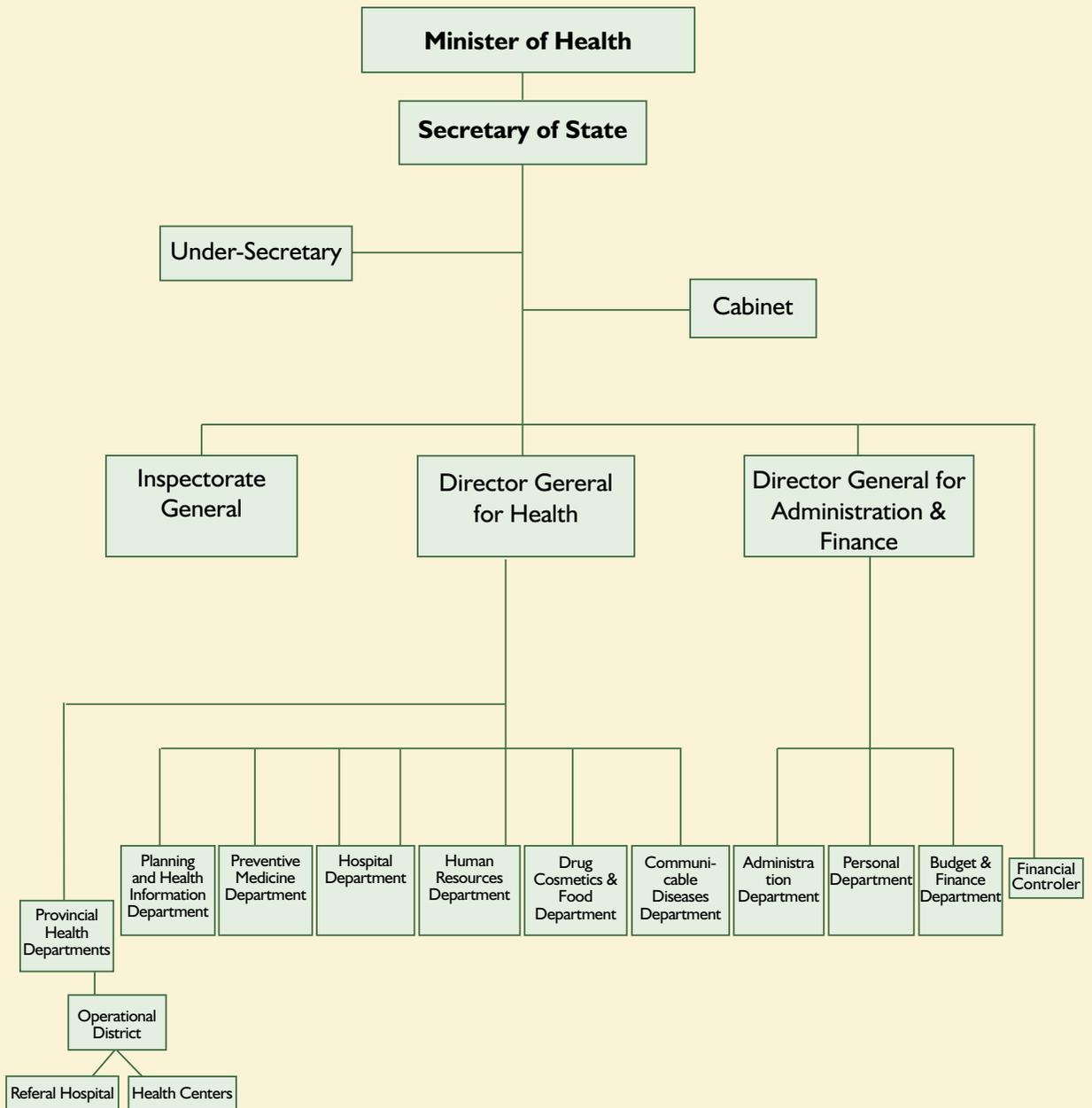
The principles of the partnership framework include:

- Consultation and sharing information on plans, financing, and management and technical support.
- Coordination to agree on co-financing and responsibilities to ensure plan outcomes.
- Respecting the ministry's choices and approaches as indicated in the strategic plan.
- Agreement on joint reviews and monitoring to: a) avoid unnecessary workload and extra burden of logistics on the government; and b) assess the contribution and comparative advantage of different partners.

ANNEXES

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Annex E: Process to develop health sector strategic plan	63

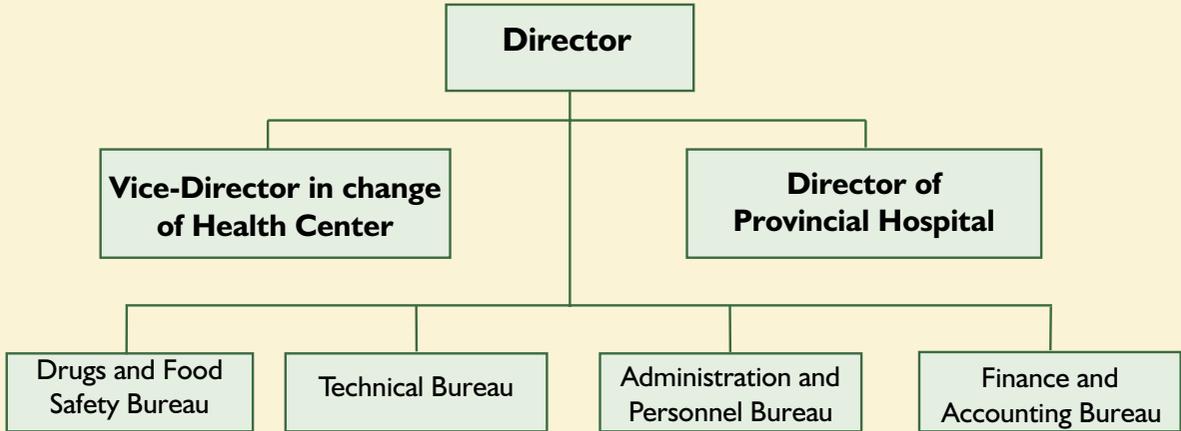
ANNEX AI. ORGANIZATIONAL CHART OF CENTRAL LEVEL MINISTRY OF HEALTH*



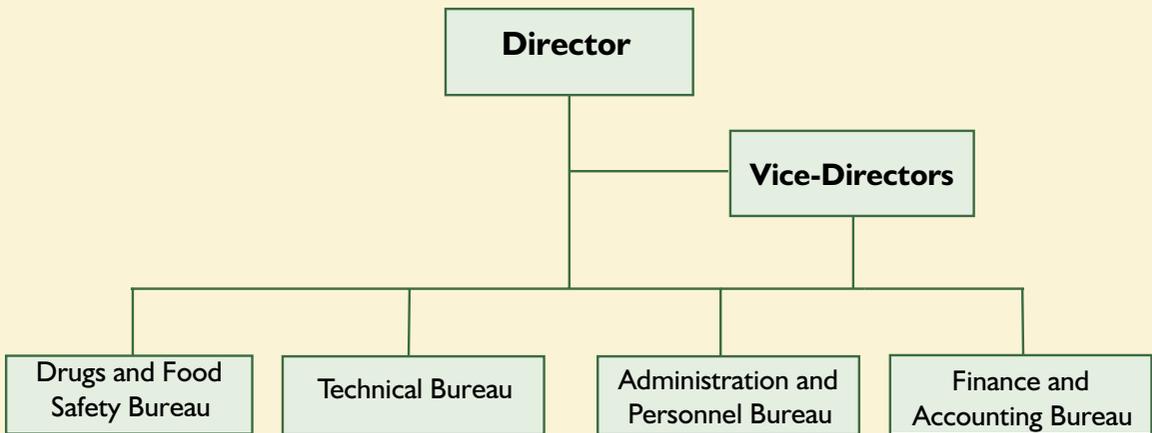
*Accounting to sub-decree No 67, 1997

ANNEX A2. ORGANIZATIONAL CHART FOR PROVINCIAL LEVEL*

ONE OPERATIONAL DISTRICT



MORE THAN ONE OPERATIONAL DISTRICT



*According to Circular No 308, 1998

ANNEX B. HEALTH SECTOR STRATEGIC PLAN FRAMEWORK



Outcomes

- Reduced IMR, MMR, U5MR, TFR, and household health expenditure especially among the poor.
- Improved nutritional status among children and women
- More effective and efficient health system

Goal of the strategic plan
 Enhance health development sector wide to improve the health of the people of Cambodia, especially mothers and children, thereby contributing to poverty alleviation and socio-economic development.

Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies
				Y1	Y2	Y3	Y4	Y5	
<u>Health service delivery:</u>									Chair /Co-chair
A. Further improve coverage and access to health services especially for the poor and other vulnerable groups through planning the location of health facilities and strengthening outreach services	Improved coverage	<ul style="list-style-type: none"> • Finish revision of health coverage plan • Convert former district hospitals to health centers according to revised health coverage plan • Strengthen outreach services • Work through inter-ministerial channels on school health, and on military and prison services 	+++ +++	●	●	→	→	→	Chair: PM Department (Dept.) Co-chair: -Hospital Dept. -Planning Dept. -National Programmes.
B. Strengthen the delivery of quality basic health services through health centers and outreach based upon minimum package of activities	Increased utilization of preventive and curative services especially by the poor	<ul style="list-style-type: none"> • Review and revise the MPA to especially target the top priority diseases and other problems such as malnutrition • Improve community participation by strengthening link between health centers and the village health support groups • Adapt and implement different packages for health posts and for outreach • Develop and implement appropriate health service delivery approaches to urban poor populations • Develop and implement a national child health initiative 	+++ +++ +++	●	→	→	→	→	Chair: PM Department Co-chair: -Planning Dept. -National Programmes
C. Strengthen the delivery of quality care, especially obstetric and paediatric care, in all hospitals through measures such as the complementary package of activities		<ul style="list-style-type: none"> • Finalise and implement CPA according to role of hospitals at district, provincial, and national level, building upon evidence based practices • Develop and implement a package of laboratory activities for different levels of the health system • Systematically improve referral system to, and emergency obstetric care in, referral hospitals 	+++ +++ ++	●	→	→	→	→	Chair: Hospital Dept. Co-chair: -Planning Dept -Pre. Med. Dept.; -National Programmes



Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies	
				Y1	Y2	Y3	Y4	Y5		
D. Strengthen the management of cost-effective interventions to control communicable diseases E. Strengthen the management and coverage of support services such as laboratory, blood safety, referral, pharmaceuticals, equipment and other medical supplies and maintenance of facilities and transport <u>Behavioral change:</u> F. Change for the better the attitudes of health providers sector-wide to effectively communicate with consumers, especially regarding needs of the poor, through sensitization and building interpersonal communication skills	Reduction of prevalence rates of communicable diseases	<ul style="list-style-type: none"> •Further develop and implement comprehensive plans for 4-6 priority diseases •Deliver priority communicable disease interventions in integrated ways at OD level through MPA delivery system 	+++	●	→	→	→	→	→	Chair: CDC Dept. Co-chair: -Planning Dept. -National Programmes -PM Dept. Chair: Drug Dept. Co-chair: -Planning Dept. -Hospital Dept. -National Blood Bank
	Increased availability of supplies and functioning equipment Effective referral system	<ul style="list-style-type: none"> •Strengthen plans and systems to ensure effective, efficient and cost-efficient management of supplies, facilities, and transport •Further develop and implement efficient, effective and cost-effective maintenance and procurement service to ensure optimal operation of equipment and facilities at all times to ensure quality services •Improve technical capacity and management including resource availability for referral system •Develop and strengthen quality of the laboratory system at all levels •Strengthen implementation of laws on drug and vaccine quality and food control 	+++	→	→	→	→	→	→	Chair: Health Promotion Centre Co-chair: -PM Dept. -Hospital Dept.
	Appropriate practices and healthy lifestyles as a result of informed decisions, especially by women	<ul style="list-style-type: none"> •Raise awareness among public, private, NGO health providers about quality health services and professional ethics (accountability) including inter-personal communication skills •Support and cooperate with pharmacists, private practitioners, professional health associations and traditional healers to promote appropriate client referral •Work with HRD to improve health providers attitudes and behaviour towards consumers •Further develop and implement procedures to monitor and evaluate providers communication skills and practices 	++	●	→	→	→	→	→	
			+	●	→	→	→	→	→	
			+++	●	→	→	→	→	→	



Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies
				Y1	Y2	Y3	Y4	Y5	
<p>J. Develop and implement minimum and optimum quality standards for the public and private sectors incorporating pro-poor and gender issues through the use of appropriate tools</p> <p><u>Human resource development:</u></p> <p>K. Increase the number of midwives through quality basic training and strengthen the capacity and skills of midwives already trained through quality continuing education</p>	<p>Improved quality of health services sector wide</p> <p>Better essential obstetric care</p>	<ul style="list-style-type: none"> • Get consumer perspective on standards of services and facilities through consumer body • Provide information to clients and staff about the development and implementation of standards • Improve the use of the routine supervision tools • Develop quality assessment and improvement tools • Set up procedures for registration, assessment, and licensing, and awards for quality <ul style="list-style-type: none"> • Continue providing 4 month maternal and child health course for health center staff • Continue continuing education training by National Maternal and Child Health Center and other training providers for referral hospitals and health center staff • Implement a one year post graduate midwifery training in 2003 • Develop a primary training programme to have midwifery staff in remote areas 	<p>+++</p> <p>+</p> <p>+++</p> <p>+++</p> <p>+</p> <p>+++</p> <p>+++</p> <p>+++</p> <p>+++</p> <p>+++</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>Chair / Co-chair</p> <p>Chair: NIPH</p> <p>Co-chair: - Planning Dept. - Regional Training Centres</p> <p>Chair: HRD</p> <p>Co-chair: - Personnel Dept. - National Institute of Public Health</p> <p>Chair: HRD</p> <p>Co-chair: - Personnel Dept - National Institute of Public Health - University of Health Sciences</p>	
<p>L. Strengthen human resource planning to reduce mal-distribution of the numbers and type of workforce through identification of posts and the reallocation of staff.</p>	<p>Improved performance and distribution of health staff</p>	<ul style="list-style-type: none"> • Reallocate midwives back to midwifery from other areas of work • Set standards to improve quality of training • Finalise the functional analysis and identify posts at each level of health system according to revised health coverage plan and health strategic plan • Consult with the Public Function Secretariat and seek approval for numbers of staff according to identified posts or new establishment needed • Identify training needs linked to posts and implement training 	<p>+++</p> <p>+++</p> <p>+++</p> <p>+++</p> <p>+++</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>	<p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p> <p>•</p>		



Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies
				Y1	Y2	Y3	Y4	Y5	
<p>O. Allocate financial resources to improve the accessibility of health services for the poor through alternative health financing schemes</p>	<p>Increased cost-effectiveness and efficiency of health service delivery systems</p> <p>Reduced financial barriers to access to hospital services for the poor</p>	<ul style="list-style-type: none"> Evaluate pilot projects to improve access by the poor and implement equity funds in selected areas Formally introduce boosting in areas with good management capacity and support from local authority Scale up official health financing schemes with user fees Continue contracting with appropriate providers in poor, remote operational districts Enable incentives to staff working in remote areas and priority mission groups 	<p>+++</p> <p>++</p> <p>+++</p> <p>+++</p> <p>+++</p>	●	→				<p>Chair: Planning Dept.</p> <p>Co-chair: -Finance Dept.</p>
<p>P. Ensure transparent, efficient and effective health expenditures through strengthening resource allocation, coordination of different sources of funds, and monitoring</p>	<p>Improved transparency in management of funds</p>	<ul style="list-style-type: none"> Improve resource allocation decision making and link to performance Establish and strengthen internal audit function Strengthen monitoring and evaluation process 	<p>++</p> <p>++</p> <p>+++</p>	→					<p>Chair: Budget and Finance Dept.</p> <p>Co-chair: -Planning Dept. International Relations Office</p>
<p><u>Institutional development:</u></p> <p>Q. Organizational and management reform of structures, systems and procedures of the Ministry of Health to respond effectively to change</p>	<p>Increased efficiency, effectiveness, and accountability of the Ministry of Health at all levels</p>	<ul style="list-style-type: none"> Clarify roles and functions, lines of accountability and decision-making, delegation of authority at all levels of the Ministry of Health, including national programmes, national hospitals and other national health institutions Designate document reference centers/focal points for national programmes/institutions, laboratories, and Ministry of Health central level departments Further develop and implement health management information system Develop an integrated planning and budgeting system in all ministry departments and institutions at all level 	<p>+++</p> <p>++</p> <p>+++</p> <p>+++</p>	●	→				<p>Chair: Planning Dept.</p> <p>Co-chair: -Budget and Finance Dept. -International Relations -Administration Department -Personnel</p>



Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies Chair /Co-chair		
				Y1	Y2	Y3	Y4	Y5			
	Laws are appropriate and fully enforced	<ul style="list-style-type: none"> • Systematically organize how to ensure evidence based decision making and practice through research and the evaluation of pilots • Develop a common protocol, clear costing, and responsibilities for contracting • Strengthen capacity to draft and implement health and health related laws and regulation; strengthen collaboration with the Ministry of Justice • Strengthen the institutional and technical role of the National Center for Health Promotion to carry out its mandate on coordination, quality assurance and training 	++	●	→	→	→	→	→	Chair	
			+++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	Hospital Dept.
			++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	-Planning Dept.
			++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	Hospital Dept.
			++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	-Hospital Dept.
			++	●	→	→	→	→	→	→	-National Programmes
R. Effective public private partnership to improve accessibility, quality and affordability through the promotion of private sector participation and enforcement of regulations.	Improved supervision and regulation of private services Increased participation of private sector in health service delivery	<ul style="list-style-type: none"> • Implement effective ways of getting compliance with regulation on registration and licensing of private facilities/ providers including pharmacies/pharmacists • Promote private sector participation in increasing health services coverage and in addressing key health issues • Encourage and support NGOs to work on essential services (mainly MPA and CPA) • Promote appropriate use and reduce harmful practice of informal sector services (traditional birth attendants, Kru Khmer, etc.) 	++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	Hospital Dept.
			++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	-Planning Dept.
			++	●	→	→	→	→	→	→	Chair:
			++	●	→	→	→	→	→	→	PM Dept.
			++	●	→	→	→	→	→	→	Co-chair:
			++	●	→	→	→	→	→	→	-Hospital Dept.
			++	●	→	→	→	→	→	→	-National Programmes
S. Enhance Ministry of Health capacity to address chronic and other non-communicable diseases and emerging public health problems through raising awareness and developing comprehensive plans.	Increased public awareness on prevention of chronic diseases	<ul style="list-style-type: none"> • Increase awareness and understanding of potential health consequences of poor diet and environmental factors such as industrial pollution, the mis-use of pesticides and global warming • Develop comprehensive plans for priority chronic and other non-communicable diseases that address prevention, screening, treatment, palliative care and rehabilitation and also plans for other problems such as 	+	●	→	→	→	→	→	→	Chair:
			+	●	→	→	→	→	→	→	PM Dept.
			+	●	→	→	→	→	→	→	Co-chair:
			+	●	→	→	→	→	→	→	-Hospital Dept.
			+	●	→	→	→	→	→	→	-National Programmes



Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies Chair /Co-chair	
				Y1	Y2	Y3	Y4	Y5		
<p>T. Further develop the health sector to strengthen management effectiveness throughout the health service by:</p> <p>1) Enhancing management and leadership culture sector-wide</p>	<p>Effective and efficient approach to sector wide management through joint planning, monitoring and evaluation</p>	<ul style="list-style-type: none"> injuries, malnutrition, mental health, and tobacco use Develop and implement health preparedness plan for disasters such as floods, and for public health crises management Further develop and implement plans for monitoring emerging public health problems such as tobacco alcohol and drug abuse Further extend and enforce occupational health measures 	+++	↔	↔	↔	↔	↔		
			+++	↔	↔	↔	↔	↔		
			++	↔	↔	↔	↔	↔	↔	
			+	↔	↔	↔	↔	↔	↔	
					+++	↔	↔	↔	↔	↔



Strategies by key areas of work	Outcomes	Strategic actions	Priority by resource allocation	Time frame (2003-2007)					Responsible Department/Institution based on the 20 Strategies
				Y1	Y2	Y3	Y4	Y5	
2) Increasing effective decentralization and deconcentration	Improved accountability and effectiveness of the health system	<ul style="list-style-type: none"> • Delegate appropriate authority enabling managers to be more responsive to service needs • Examine all possible options and implement selected options for effective management of hospitals • Encourage the establishment of public administration institutions particularly hospitals, on a case by case basis • Ensure that any autonomous hospital provides the services required by the poor effectively and efficiently 	++	←	→	→	→	→	Chair: Planning Dept. Co-chair: - Budget and Finance Dept. - International Relations Office - Administration Dept. - Personnel Dept. - National Programmes
			++	←	→	→	→	→	
			++	←	→	→	→	→	
			++	←	→	→	→	→	
3) Institutionalizing sector wide management	Improved stewardship of the sector by the Ministry of Health	<ul style="list-style-type: none"> • Continue the development of sector wide approach and ensure consistency with the health needs of the population • Strengthen international cooperation and relations through the further development of the international relation office • Improve capacity of Ministry of Health to coordinate sector financing 	++	←	→	→	→	→	Chair: Planning Dept. Co-chair: - Budget and Finance Dept. - International Relations - Administration - Personnel
			++	←	→	→	→	→	
			++	←	→	→	→	→	

ANNEX C. HEALTH SERVICE DELIVERY COMPONENTS 2003-2007

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level		CPA (Complementary Package of Activities) Referral Hospital Level			Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital) 1	CPA+ (Provincial Hospital) 2	CPA++ (Some Provincial Hospitals) 3		
I.1 Immunization	80% of children below 1 year of age fully immunised	<ol style="list-style-type: none"> 1. Community mobilization 2. Register target groups 3. Provide immunization information education 4. Information education communication 5. Surveillance on vaccine preventable diseases 	<ol style="list-style-type: none"> 1. Provide immunization 2. Assess, manage and notify (alert system) preventable diseases and AEFI (adverse events following immunisation) 3. Refer severe cases 4. Health education 	<ol style="list-style-type: none"> 1. Newborn immunization (BCG, OPV₀) 2. Check immunization status and refer for completion 3. Management of referred cases 4. Assess, notify (and refer) AEFIs 5. Health education 	Same as 1	<ol style="list-style-type: none"> 1. Same as 2 and diagnosis of severe cases and AEFI. 	<ol style="list-style-type: none"> 1. Same as at Health Centre level for #2, #3 and #4 2. Provide immunization according to NIP protocol under the authorization of the Ministry 	Same as with CPA++
I.2 Management of Pediatric Illnesses (Acute Respiratory Infections, Diarrhoea, Dengue, Malaria, Malnutrition, ORT, 35% given Measles, etc.)	<ol style="list-style-type: none"> 1. At least 50% of children with ARI and/or fever are brought to a qualified provider 2. 80% children with diarrhoea given ORT. 35% given ORS 	<ol style="list-style-type: none"> 1. Detect severely sick children and refer 2. Promote appropriate home treatment (e.g. oral rehydration) and care seeking behavior 	<ol style="list-style-type: none"> 1. Comprehensive assessment and treatment (through Integrated Management of Childhood Illness) 2. Counseling of mothers and health education 	<ol style="list-style-type: none"> 1. Management of referred cases 2. Counseling of mothers and health education 	Same as 1: Surgical services	Same as 2: Specialized services	<ol style="list-style-type: none"> 1. Provide health care according to national guidelines 	
I.3 Nutrition and Growth Promotion	<ol style="list-style-type: none"> 1. 35% to start breastfeeding in 1st hour of birth 2. 25% infants under 5 months exclusively breastfed 3. Reduce underweight to 31% among children 6-59months 4. Reduce iron deficiency anemia to 43% in pregnant women and 42% in children 6-59months 5. Increase households using iodised salt to 80% 	<ol style="list-style-type: none"> 1. Distribution of micronutrient supplements (Vit A, Iron/Folic acid) 2. Information Education Communication on appropriate infant and young child feeding 3. Regular growth monitoring focusing on children <2 yrs. 4. Promotion of iodised salt use 5. Detection and treatment of anemia 	<ol style="list-style-type: none"> 1. Assess nutritional status of all children 2. Provide Vit A supplementation and deworming 3. Identify nutritional deficiencies, feeding problems and counsel, treat, refer 4. Promotion and counseling on appropriate infant and young child feeding 5. Regular growth monitoring of children <2 yrs. 6. Promotion of iodised salt use 7. Law enforcement on marketing of breast milk substitute (formula etc.) 	<ol style="list-style-type: none"> 1. Same as at Health Centre 2. Management of severe malnutrition and anemia 3. Specialised rehabilitation centers for malnutrition 4. Law enforcement on marketing of breast milk substitute (formula etc.) 	Same as 1	<ol style="list-style-type: none"> 1. Same as 2 2. Training 	<ol style="list-style-type: none"> 1. Same as 1 2. Law enforcement on marketing of breast milk substitute (formula etc.) 	

I. Child Health and Nutrition

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level		CPA (Complementary Package of Activities) Referral Hospital Level			Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital) 1	CPA+ (Provincial Hospital) 2	CPA++ (Some Provincial Hospitals) 3		
1.4 Neonatal care	<ol style="list-style-type: none"> Increase delivery by trained health staff to 60% (2001-2005) Elimination of neonatal tetanus by 2005 	<ol style="list-style-type: none"> Promote clean childbirth practices (hand washing, umbilical care) and essential neonatal care (e.g prevention of hypothermia and hypoglycemia) Provide BCG, OPV₀ and give yellow card through outreach 	<ol style="list-style-type: none"> Promote early breast feeding Provide immunization according to national protocol. 	<p>Management of referred cases</p>	<ol style="list-style-type: none"> Same as 1 Neonatal intensive care 	<p>Same as 1</p> <p>Research</p>	<ol style="list-style-type: none"> Follow national protocol Notification of cases to public sector. 	
2. Maternal Health								
2.1 Reproductive Health	<ol style="list-style-type: none"> Reduce maternal mortality ratio by 8% Improved antenatal care coverage by 60% (at least 2 antenatal care visits by trained health staff) Reduce night blindness to 4% among pregnant women. 	<ol style="list-style-type: none"> Provide information education on healthy pregnancy, safe delivery and birth spacing Provide Tetanus Toxoid vaccination Detect and refer pregnant women with high risks to appropriate facility. Provide obstetric first aid Breastfeed within one hour of delivery 	<ol style="list-style-type: none"> Same as outreach Get obstetric history Provide antenatal care check up and Iron/folate supplementation through outreach Reproductive tract infections screening and treatment Provide basic emergency obstetric care 	<ol style="list-style-type: none"> Same as at Health Centre Perform blood grouping Provide expanded emergency obstetric care 	<ol style="list-style-type: none"> Same as 1 Provide comprehensive emergency obstetric care 	<ol style="list-style-type: none"> Same as 2 Treatment of referred cases 	<p>Follow Ministry's policy and guidelines.</p>	
<ol style="list-style-type: none"> Delivery - Essential Obstetric Care and Emergency Obstetric Care Post-partum Care 	<ol style="list-style-type: none"> Increase delivery by trained health staff to 60% (2001-2005) Increase justified Caesarian section to 2%. <p>Increased coverage of postnatal care by trained health staff</p>	<ol style="list-style-type: none"> Home delivery by trained providers Newborn care Health education Vit A supplement Organise transport for obstetric emergency Counseling on diet, danger signs, breast feeding, birth spacing and immunization Perineum, breast care Early detection of complications and referral 	<ol style="list-style-type: none"> Same as outreach Conduct normal delivery Provide basic emergency obstetric care and refer as appropriate Same as outreach postnatal care Provide micronutrient supplementation (e.g Vit A, iron, folate) Refer complications 	<ol style="list-style-type: none"> Same as Health Centre Conduct normal and assisted delivery Provide expanded emergency obstetric care and referral 	<ol style="list-style-type: none"> Same as 1 Provide comprehensive emergency obstetric care 	<ol style="list-style-type: none"> Same as 2 Clinical trial study/ research 	<p>Follow national guideline</p>	
			<ol style="list-style-type: none"> Same as at Health Centre Management of referred cases and other complications 	<ol style="list-style-type: none"> Same as 1 Treat reproductive tract infections, manage post-partum haemorrhage and other complications 	<ol style="list-style-type: none"> Same as 1 Manage post-partum mental disorders 	<ol style="list-style-type: none"> Same as 2 Provide postnatal care services according to national protocol and authorization 		

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level			CPA (Complementary Package of Activities) Referral Hospital Level			Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital) 1	CPA + (Provincial Hospital) 2	CPA + + (Some Provincial Hospitals) 3			
2.1.2 Birth Spacing	Increased contraceptive prevalence rate to 35%.	1. Inform and provide pills, condoms. 2. Counseling and referral for other method 3. Treat or refer side effects and complications	1. Same as outreach 2. Injections 3. Intra-uterine devices at selected Health Centres 4. Treat side effects.	1. Same as at Health Centre 2. Norplant if available.	1. Provide permanent methods. 2. Treatment of side effects and complications	1. Same as 2 2. Clinical trials / research	1. Social marketing for pills, condoms (sales outlets, pharmacies) 2. Community-based distribution to underserved 3. Provide services		
2.1.3 Abortion a) Safe abortion b) Post abortion management	1. Reduce septic abortion 2. Reduced complications from abortion 3. Reduce fatality due to abortions.	1. Inform and refer to appropriate facility 2. Provide birth spacing methods	1. Same as outreach 2. Assess and manage abortion cases 3. Refer septic abortions and complications. 4. Provide birth spacing methods.	1. Manage referrals 2. Safe abortion 3. Manage septic abortion 4. Refer complications	1. Same as 1 2. Blood transfusion. 3. Surgery if needed	1. Same as 2	Follow Ministry's guidelines		
3. Communicable Disease Control									
3.1 Sexually Transmitted Infections a) Case management and education for general population	STI case management based on syndromic approach will be available in all MPA Health Centres	Encourage people to get STI treatment properly	1. Treatment using syndromic approach by Health Centre staff in 200 Health Centres 2. Health education		1. Clinical diagnosis by laboratory staff in 20 provinces 2. Information communication by infectious disease ward staff	Information education by infectious disease ward staff	1. Clinical diagnosis and treatment by national clinic staff 2. Information education by NGOs staff 3. Training of private practitioners on STI syndromic approach	1. Diagnosis and treatment by national clinic staff 2. Special campaign for special events	
b) Case management and education for high risk group to support 100% condom use programme	At least 90% of direct sex workers will receive regular STI check-up and treatment	Information education by peer educator in the community	Special STI clinic for high risk population						Clinical diagnosis, treatment by Provincial STD clinics (27 specialised clinics)

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level		CPA (Complementary Package of Activities) Referral Hospital Level				Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital) 1	CPA + (Provincial Hospital) 2	CPA ++ (Some Provincial Hospitals) 3			
3.2 HIV/AIDS a) 100% condom use program b) Care and support to patients c) Voluntary Counseling and Testing d) HIV research e) HIV/AIDS and STD surveillance f) Prevention of mother to child transmission	1. Work with authorities and brothel owners for 100% condom use 2. Reduce HIV seroprevalence rate to 2.1% by 2007 3. All commercial and casual sex acts are protected by condoms 4. All patients with HIV disease referred to the appropriate level in continuum of care 5. Voluntary testing and counseling available on demand in all urban centres 6. All HIV positive pregnant to receive counseling, all newborns exposed to HIV will receive appropriate therapy and care	7. Work with authorities and brothel owners etc for 100% condom use 8. Home based palliative care to support persons living with AIDS by 2 Health Centre staff in collaboration with NGOs staff and community based organisations	Provide information education communication / counseling on prevention of mother to child transmission	Provide voluntary testing and counseling	Same as 1 Care and treat opportunistic infections	Same as 2 Same as 2 Clinical research		1. Provide voluntary testing, counseling and treatment by national clinic	
3.3 Tuberculosis	High Cure rate > 85% Case Detection (at least 70%)	1. Health Education 2. Defaulter tracing 3. Early detection of cases 4. Refer suspect and/or severe cases 5. Directly Observed Treatment Short Course (DOTS) at home	1. Early detection, send sputum for investigation or refer to TB unit 2. DOTS for TB patients 4. Refer severe cases 5. Screen close contacts 6. Health Education	1. DOT for inpatient and ambulatory cases 2. Health education 4. Quality control of slides by the TB laboratory	Same as 1	Same as 2	Early detection and refer with sputum sample for investigation at nearby TB units		
3.4 Leprosy	Reduce prevalence rate to less than one case per 10,000 population	Early detection and referral	1. Health education patients 2. Follow up leprosy cases 3. Refer all suspected cases 4. Treatment of cases	1. Treat confirmed cases according to protocol 2. Follow up leprosy patients 3. Contact examination	1. Same as 1 2. Contact examination monitoring	Surgery	1. Refer all suspected cases	1. Confirm, treat and follow up all leprosy patients 2. Contact examination 3. Rehabilitation	

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level			CPA (Complementary Package of Activities) Referral Hospital Level			Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital)	CPA+ (Provincial Hospital)	CPA++ (Some Provincial Hospitals)			
3.5 Dengue Haemorrhagic Fever	Reduce case fatality rate to less than 1% nationwide Reduce annual morbidity rate to less than 60 per 100,000	Health education on dengue prevention	1. Detect and refer severe DHF cases to district hospital 2. Assess and classify cases and refer 3. Report suspect cases 4. Health education on dengue prevention	1. Assess and classify dengue cases and refer if needed. 2. Treatment dengue cases according to national guideline 3. Health education and community mobilisation 4. Report cases to Provincial Health Dept. 5. Report possible outbreaks to the Provincial Health Dept.	1. Assess classify and treat severe cases 2. Refer if needed 3. Mobile health education before and during outbreak period 4. Report cases 5. Collect and send specimens for virological testing 6. Entomology surveillance 7. Investigation and outbreak response	1. Manage severe cases 2. Health education 3. Report to Communicable Disease Control Dept., Ministry of Health	1. Provide treatment according to guidelines and refer. 2. Health education on dengue prevention 3. Report to DHF control programme, Ministry of Health on a weekly basis	1. Pre-emptive strike with mass larviciding in high risk areas 2. Mass media health education campaigns	
3.6 Malaria 3.6.1 Clinical Management, prevention and surveillance	Reduce the malaria morbidity and mortality by 30% (compared to the baseline year 2002).	1. Early diagnosis of simple malaria with dipsticks and treatment with blister packages by volunteers, health practitioners 2. Referral of severe and complicated malaria. 3. Health education on the use of bed nets by volunteers 4. Monitoring the use of nets at family level	1. Early diagnosis of simple malaria with microscopy and treatment according to protocol 2. Refer severe cases 3. Health education 4. Report cases	1. Same as health center 2. Treat referred cases 3. Refer complicated malaria cases for dialysis if needed	1. Same as 1 2. Treatment of referred cases 3. Refer complication for dialysis if needed	1. Same as 2	1. Provide treatment according to national protocol and refer 2. Report cases 3. Participate as outlets in social marketing of rapid test, combination therapy and hammock nets	Purchase and distribution of bednets and insecticide to provinces	
3.7 Lymphatic Filariasis	100% of endemic implementation units to be under mass chemotherapy by 2007	1. Mapping endemic areas 2. Mass drug administration unidentified implementation units	1. Early diagnosis of new cases and refer 2. Clinical management of elephantiasis disability	1. Treatment of new cases 2. Store drugs for mass drug administration	Same as 1	Same as 2	Refer new cases to district hospital	1. Collection of all old cases 2. Prepare and launch MDA at all IUs 3. Surgery for elephantiasis	
3.8 Schistosomiasis Helminthiasis	Reduce morbidity due to - Schistosomiasis less than 5% and maintain the low prevalence - Helminthiasis less	1. Monitor the prevalence at sentinel villages for Schistosomiasis 2. Baseline survey, mass drug administration for Helminthiasis	1. Health education 2. School health education and deworming 3. Passive case detection and treat symptomatic cases	1. Health education 2. Passive case detection and treatment 3. Refer severe cases of Schistosomiasis	Treat severe Schistosomiasis and refer for surgery	Same as 2	Report to National Malaria Centre	1. Conduct surveillance 2. Monitor and evaluate 3. Annual mass treatment 4. Develop IEC	
3.9 Disease Surveillance (Alert system) and Outbreak Response	Reduce morbidity and mortality of outbreak prone diseases	Active case finding by Health Centre staff	1. Report, investigate and treat according to national guidelines 2. Refer severe cases	1. Same as at Health Centre 2. Treat referred cases	Same as 1	Same as 2	Notify and refer cases according to protocol	Outbreak intelligence and coordination of control interventions	

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level		CPA (Complementary Package of Activities) Referral Hospital Level			Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital) 1	CPA+ (Provincial Hospital) 2	CPA++ (Some Provincial Hospitals) 3		
4. Other Components								
4.1 Eye Care	<ol style="list-style-type: none"> Reduced blindness rate to < 0.5% To eliminate locally endemic blindness 	<ol style="list-style-type: none"> Health education on primary eye care Provide basic eye care in community 	<ol style="list-style-type: none"> Provide primary eye care services; Refer patients. 	<ol style="list-style-type: none"> Treat referred patient Refer complications 	<p>Eye care services delivery by Basic Eye Doctors based on protocol.</p>	<p>Specialized eye care services</p>	<p>Provide eye care based on national guidelines</p>	
4.2 Oral Health	<ol style="list-style-type: none"> Reduce decayed teeth (Caries dentaire) for all Better oral health 	<p>Provide appropriate information education communication</p>	<p>Oral health education and treatment</p>	<ol style="list-style-type: none"> Oral health education and treatment Specialized surgery 	<p>Same as (2)</p>	<p>Provide oral health services by Ministry's authorization and procedures</p>		
4.3 Mental Health	<ol style="list-style-type: none"> 50% of patients could access mental health services 	<ol style="list-style-type: none"> Early detection Basic psychosocial intervention and education Promotion of basic family-based rehabilitation Promotion of community participation 	<ol style="list-style-type: none"> Same as outreach Treat cases according to protocol Refer severe and complicated cases Basic counseling Prevention according to protocol 	<ol style="list-style-type: none"> Same as Health Centre Treat severe cases (Outpatient Dept) Treat severe cases in crisis center Liaison psychiatry 	<ol style="list-style-type: none"> Same as 1 Treat very severe and complicated cases. Basic rehabilitation Counseling 	<ol style="list-style-type: none"> Same as 2 Family session Counseling Psychotherapy 		
4.4 Health Care of the Elderly	<p>70% of people above 60 years and their families aware of the prevention of chronic diseases and disabled factors</p>	<ol style="list-style-type: none"> Health education Search for disabled elderly persons Community mobilization for long term care 	<ol style="list-style-type: none"> Health education Provide health care 	<p>Same as at Health Centre</p>	<p>Same as 1</p>	<p>Same as 2</p>	<p>Same as 3</p>	
4.5 Injuries and Accidents	<ol style="list-style-type: none"> Injured patients have access to appropriate palliative treatment and rehabilitation services Increase public awareness on injury prevention especially to the head 	<ol style="list-style-type: none"> Provide public health education Refer severe cases 	<ol style="list-style-type: none"> Provide community-based rehabilitation Health education 	<ol style="list-style-type: none"> Same as Health Centre Physical rehabilitation Provide appropriate case management 	<p>Same as 1</p>	<p>Same as 2</p> <p>Prosthetic/ orthopaedic care</p>	<p>Provide services according to protocol</p>	

Components	Desired Outcome by the end of 2007	MPA (Minimum Package of Activities) Health Centre Level		CPA (Complementary Package of Activities) Referral Hospital Level			Private Sector	National Programme / National Hospital
		Outreach	At Health Centre	CPA (District Hospital) 1	CPA + (Provincial Hospital) 2	CPA ++ (Some Provincial Hospitals) 3		
4.6 Cancer prevention, treatment and care	<ol style="list-style-type: none"> 70% of cancer patients are registered 70% of population has access to primary prevention 30% reduction of morbidity rate from common cancers 20% of cancer patients can access palliative and pain relief care 	<ol style="list-style-type: none"> Provide health education Refer suspected cases of cancer Palliative care 	<ol style="list-style-type: none"> Same as outreach Health education on self breast examination Early detection on common cancer Refer suspected cases of cancer 	Same as Health Centre	<ol style="list-style-type: none"> Same as 1 Provide palliative and pain relief care Management of referred cases 	<ol style="list-style-type: none"> Same as 2 	Same as 3	
4.7 Prevention and Control (Diabetes, Cardiovascular Diseases)	<ol style="list-style-type: none"> 50% of population over 35 years old aware of the need for routine healthy medical check up 	<ol style="list-style-type: none"> Provide health education Refer suspected cases 	<ol style="list-style-type: none"> Early detection of cases Refer suspected cases Health education 	<ol style="list-style-type: none"> Same as at Health Centre Level Management of referred cases 	Same as 1	Same as 2	Same as 3	
4.8 Disaster Management	Reduce disaster impact on health by 80%	<ol style="list-style-type: none"> Awareness of preparedness response Health education First aid Active disease surveillance 	<ol style="list-style-type: none"> Health education First aid Referral 	<ol style="list-style-type: none"> First aid Surgical treatment Refer 	<ol style="list-style-type: none"> Same 1 Mass casualty management 	Same as 2	Disaster preparedness and response according to national guidelines	Same as 3
4.9 Environmental Health	Reduce the health impact of polluted environment especially by arsenic and pesticides	Health education, awareness of risk areas, collaboration with other ministries and NGOs		<ol style="list-style-type: none"> Clinical surveillance on the diseases caused by arsenic Provide intervention measures Referral 	<ol style="list-style-type: none"> Same as 1 	Same as 2		

ANNEX D: GLOSSARY OF TERMS

Accelerated district development (ADD)

A budgetary reform programme that was first initiated in 1996 to enable operational district health teams to gain more access to national budget funds as a complementary measure to the existing disbursement system. The allocations are specified in a special portion of the budget, Chapter 13, and disbursed from provincial treasury and released directly to operational district teams as cash advances.

Audit and Clinical audit

Audit is an investigation into whether an activity meets explicit standards, as defined by an auditing document, for the purpose of checking and/or improving the activity audited. Clinical audit is the systematic critical analysis of the quality of care, including the procedures for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.

Autonomous

The ability of an institution to manage and take decisions without being controlled by the government. However, strategic direction is provided by a board or a steering committee. In Cambodia, the term 'public administration institution' is commonly applied.

Birth spacing

In Cambodia birth spacing is understood as the practice or method to delay births, i.e. extend the interval between births, usually but not always, within marriage.

Boosting

Performance-based contracts to provincial and district health departments who in turn issue sub-contracts to health facilities to deliver health services based on working principles of ensuring quality, coverage targets, social development outcomes with delegated authority on management and regulation of staff and finances

Budget management centers

Cost centres with responsibility to manage and spend an allocated budget from the government specific to their activities. The configuration is as follows:

- The central Ministry of Health as Central Budget Management Centre Level 1, national institutes and national programmes - Central Budget Management Centre, Level 2;
- The provincial health departments - Provincial budget management centers level 1 and operational district offices Provincial Budget Management Centre, Level 2.

Chronic conditions

Health problems that persist over time and require some degree of health care management. Examples include cardiovascular disease, cancer, diabetes, and depression. The prevalence of chronic conditions is rising worldwide because of increased longevity, urbanisation, unhealthy lifestyles, and the spread of smoking.

Complementary package of activities (CPA)

A package of services for delivery at referral hospitals, complementary to the package for primary care services, the minimum package of activities (MPA) at health centre level. The CPA has different levels of care, i.e. by secondary, tertiary and sub-speciality (at national hospitals). These levels are termed CPA, CPA+ and CPA++.

Contracting out

Contracting an agency to deliver health services in a given area (district / provincial) with full authority to manage systems and personnel, including hiring and firing, setting salaries and prices with agreement to ensure outcomes based on health policy framework of the government

Contracting in

Contracting management from an agency to run government health services in a given area (district/provincial) within civil service rules and regulations to ensure outcomes based on the health policy framework of the government

Decentralisation and Deconcentration

'Decentralisation' is about devolving central government authority or systems to other levels. Decentralisation is a means to an end and not an end in itself. Decentralisation requires a number of preconditions including sufficient local administrative and managerial capacity as well as financial decentralisation. Monitoring is also important as is striking a balance between tight control and the independence needed to motivate providers.

'Deconcentration' is mainly about rationalising workforce at the lower levels of the system, in order to empower peripheral personnel for efficient management and implementation.

Disasters and Public health crises

When using the word 'disasters' in Cambodia people are usually referring to either natural disasters such as a hurricane or man-made ones e.g. a fire or flooding due to soil erosion. Public health crises is a term used to describe events to which health protection services have to respond. Such events might be major outbreaks of infectious diseases, industrial accidents releasing toxic fumes, chemical or biological contamination of water supplies, major epidemic in animals that has implications for human health, or an act of terrorism such as a bomb blast.

Equity

Equity can be defined in very general terms, as an appreciation of what collectively is just to distribute equally between individuals or groups.

Equity Fund

A fund to pay for health services for the poor in order to promote access and lower price barriers to priority health services; the fund may be financed through public and/or external resources.

Evaluation

Evaluation is attributing value to an intervention by gathering reliable and valid information about it in a systematic way, and by making comparisons, for the purposes of making more informed decisions or understanding causal mechanisms or general purposes.

Evidence-based decision making

This is fundamentally, the process of ensuring that the right questions are asked. Is an intervention safe and effective (will it do more good than harm)? Who needs it? Can it be provided under conditions of equal accessibility? Who is the population at risk and what are the relevant clinical and social determinants? What change may be expected in the burden of disease? What are the social consequences? If decisions are based on such comprehensive evidence then the budgetary issues that follow will be more accurately circumscribed.

Exemption

Official permission not to pay for services that one would normally have to pay for.

Goal

An end that an organisation/agency strives to attain based on strategies and plans

Health

In this strategic plan the word 'health' includes population and nutrition

Health action

Any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health.

Health policy

The health policy is the Royal Government of Cambodia's guide to the overall context within which all health and health related work should be developed and implemented.

Health policy analysis

The assessment and opinion on the outcomes and effects of past policies on health status, coverage indicators and organisational issues and the contributing factors to these changes

Health policy statement

A concise interpretation of the health policy

Health sector strategic plan

This sector wide strategic plan is the direction and scope of work in the health sector during the period 2003 - 2007. The strategic plan helps answer the question 'how are we going to successfully achieve the policy statement'? It outlines how all stakeholders can contribute to improving and sustaining the health of the people of Cambodia. The strategic plan reflect strategic thinking, leadership, a wide consultative process, evidence based decision-making, and responsible management.

In the strategic plan there is a goal and strategies for each of the the six areas of work identified as priority if people's health is to be improved by 2007. The strategic plan does not give detail on activities. This is covered in the annual operational plans developed at each level of the health system (see volume 4). Nor does it give detailed information on financial allocations. This is in the medium term expenditure framework (see volume 2). But the strategic plan does reflect some thinking about priority actions and on matching resources to the changing environment.

Health system(s)

A health system comprises all the organisations, institutions and resources that are devoted to producing health actions and outcomes. Health system are constituted, on the one hand, by a system of care whose goal is to correct health problems, prevent their appearance and conceal their consequences. On the other hand, they are formed by a system whose goal is to promote the health of populations.

Indicators

Indicators are measures for checking on progress towards achieving outcomes. They can be quantitative and/or qualitative, have a time frame, and may highlight geographical and/or target groups. Indicators should relate to those aspects of care or organisational/management issues which can be altered by staff.

Institutional development

Refers to the process and content of change in institutions. The term process covers 'how' change is achieved and the term 'content' refers to 'what' is to be achieved.

'How' concerns change management or organization development, e.g. how need for change is identified and accepted; how change programmes are designed and agreed, and how implementation is organized. 'What' relates to the changes that are to be made, e.g. redefining objectives of new human resource policies.

Integration

Measures to make whole or complete by combining or bringing parts of a system together. In the Cambodian health sector, this means merging and/or combining planning and management activities of different health and disease control programmes into one consolidated plan at the provincial and district levels.

Medium term expenditure framework

Sector level financial plan that shows allocation of expenditures including an indication of sources of funds against planned activities and is reviewed annually and rolled over to the subsequent year.

Mission statement

The mission statement of the Ministry of Health provides a sense of purpose and reflects the Constitution and Decrees of the Royal Government of Cambodia.

Minimum package of activities (MPA)

A package of preventive and curative services at primary care/health centre level designed to address priority health problems.

Monitoring

Continuous supervision of an action/activity, which compares the work to the strategic plan and/or annual operational actions for the purpose of checking whether plans and procedures are being followed and will contribute to the successful achievement of a desired outcome.

Operational plan

A yearly agenda of work that indicates all major activities and financial allocations, ranked in order of priority, and tells us the detail of what is needed to achieve the intended outcomes of the strategic plan.

Outcomes

Outcomes are the real or visible effect of decision-making and practice. They should relate to crude rates of adverse events in the population (these give the best indication of the size of a health/disease problem) or when qualitative relate to issues that are system wide.

Outreach

Extension of services from a health facility to specific villages or communities through regular planned visits by health providers from that facility. In Cambodia, the term applies to visits by health centre staff in mobile teams that travel to villages or urban slums and deliver a package of a few preventive and curative services included in the minimum package of activities.

Priority action programme (PAP)

A budgetary system that was first piloted in September 2000 to enable provincial health departments to have increased access to national health budget allocations. The funds are disbursed through a specially designated portion of the national budget, i.e. the Chapter 13 and are released through a post-audit system from the provincial treasury to the provincial health department.

Private sector

The part of the economy of a country that is not under the direct control of the government. There are a number of different players in the private sector in Cambodia. These can be summarised as: private-for-profit, private not-for-profit, and informal sector.

Public sector, and Public health

In the strategic plan the 'public sector' refers to services funded and managed by/within national government systems. Public health is defined as the health of populations/communities as opposed to the health of individuals.

Quality management, Quality prevention and care, Quality of life, Professional quality, and Quality assurance

Quality management is the degree of excellence of a service or a system in meeting the health needs of those most in need at the lowest cost, and within limits, directives and/or regulations. This means looking at issues including equity, accessibility, effectiveness, efficiency, appropriateness and responsiveness. Baselines for quality include: setting national and local level standards, clinical audit, legal rights, and in many countries a patient's charter, patient ombudsman, and a tribunal for patients' rights comprised of ordinary citizens

Quality prevention and care is measured to a great extent by clinical audit (see earlier definition). To move towards higher quality prevention and care, more and better information is commonly required on existing provision, on the interventions offered and major constraints on service implementation. Local and national risk factors need to be understood. Information on numbers and types of providers is a basic requirement. An understanding of provider attitudes and practices and on client utilisation patterns is also needed so that policy makers know why the array of provision exists, as well as where it is going.

Quality of life is about adding life to years. People in many societies nowadays are not worried about dying. They are more concerned about the process of living and dying – will it be painful? Will there be much ill health and/or disability?

Professional quality: professionals' views of whether the service meets patients' needs as assessed by professionals (outcome being one measure), and whether staff correctly select and carry out procedures which are evidence based and necessary to meet patients' needs.

Quality assurance is a general term for actions and systems for monitoring and improving quality. It involves measuring and evaluating quality, but also covers other activities to prevent poor quality and ensure high quality.

Regulation

A rule, ordinance or law by which conduct is ensured at established standards

Sector wide

Sector wide means all institutions, organizations, and agencies, whether public, private, local or international, within the specified sector.

Sector-wide management

Refers to formulating policy and managing all agencies and organisations, both public and private, with a common strategy and mutually agreed management arrangements

Sensitisation

To make somebody more aware of, and better understand, a particular issue or problem, e.g. to make health providers understand the importance of consumer feedback in developing quality health care

Stewardship

Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information

Strategic options

Broad directions to be chosen based on analysis of what is feasible, has high potential to attain the goal, outcomes and targets, and is within available resources

Standards

Requirements or limits established for use as a rule or basis of comparison in measuring or judging capacity, quantity, and/or quality

Target

The targets in this strategic plan (in box 1a) are those parts of the population i.e. under fives, pregnant women, people aged 15-49 years of age (for HIV/AIDS control) or whole populations i.e. in malarial areas or where dengue is prevalent, which when implemented effectively and efficiently the strategic plan will have a major impact upon.

Values

Values and principles embody the ideals of the Ministry of Health and offer a 'moral' or 'ethical' code that guides decision making to achieve success. They are valuable in communicating the reasons behind decisions should they be questioned.

Working principles

Moral rules or strong beliefs that are meant to guide the every day work of the entire workforce

ANNEX E: PROCESS FOR DEVELOPING HEALTH SECTOR STRATEGIC PLAN

The process of decision making about the direction and scope of the Ministry of Health strategic plan for the health sector was designed mid 2001 and planned to last one year, September 2001-September 2002. It particularly built upon the thinking surrounding the development of a sector wide approach, started in 1999, and the findings of the joint sector review undertaken in 2000. A Core Group was established to take the work forward (see the acknowledgements section).

One of the first design steps that the Core Group took was to draw a road map. This outlined a process involving eight crucial steps to be taken during the year if the product, this strategic plan and the other three volumes, was to address priority health and disease problems in Cambodia –see Figure 5.

The intention of the one-year time frame was also to allow top and senior management decision makers and busy planners and implementers, the time to reflect on and own the direction, scope, and implications, of the strategy as it evolved. The process also aimed to help ensure that the strategic plan is realistic and affordable.

A feature of the road map is opportunities for an ongoing and transparent consultative process with other ministries, with national and international partners and with other stakeholders such as those in the private health sector. Contact with other ministries has been crucial during the process to help ensure the strategic plan is linked to broader reforms within government and that it reflects recognition that improving health status depends on actions in other sectors as well as in the health sector. The process has also proactively engaged local professional organizations and non-governmental organisations and international external agencies in decision making about priorities, strategies, and the overall content of the strategic plan.

A number of formal and informal meetings have taken place at different levels of the health system. Within the existing structure and management system of the Ministry of Health one of the most useful forums to promote dialogue/debate, consultation, and clear understanding about the strategic plan as it evolved has been the monthly coordination committee (CoCom) at central level, and at provincial level, during meetings of the health management teams. Senior management in the ministry has also had a number of strategic ‘think tank’ meetings to discuss and make decisions about critical choices and other issues such as the mission statement, values, working principles, and policy statement.

Meetings specifically organised to help with the development of the strategic plan included two national workshops. The main output from the first workshop, January 2002, was a list of priority health issues that fell into six topics. These subsequently became the priority areas of work in box 10, Chapter 3. A working group was formed for each of the six areas and between January and April 2002 each met to discuss and write a situational analysis and draft strategies. Members of the working groups came from different levels of the health system. The comparative advantage of different NGOs and donor partners was reviewed and some were nominated to work with the different working groups. The working groups presented their draft strategies at a second national workshop, May 2002.

After the workshop and for the rest of May a small group of five people refined the draft strategies and drafted the strategic plan. To facilitate this they wrote guidelines for drafting and developed a process to evaluate what they were writing. The first official draft of the strategic plan was reviewed towards the end of the month by a panel of reviewers and in senior management meetings, and then re-drafted as a result of feedback. The ownership factor was further reinforced in June when the draft strategic plan was circulated widely among ministry, government and national and international partners for comment.

The road map reflects the recognition that it is not enough to just produce a strategic plan. There is a danger that implementers in particular, read it, and then put it on a shelf and forget about it because no tools are available to help with implementation. So, while the strategic plan itself was being developed the ministry also worked on revising the planning manual, reviewing the planning-budgeting cycle, and producing three frameworks: a) for planning and expenditures; b) for monitoring and evaluation; and c) for annual operational plans. These are now respectively volumes 2, 3 and 4 of this strategic plan, which is volume 1.

Figure 5. Summary of the consultative process for the development of the Kingdom of Cambodia, Ministry of Health, Health Sector Strategic Plan 2003-2007

